



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93D

02874

144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick
City or town Thurmont.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. East Street
(If rural, give LOCATION) no
2.(a) If veteran, name war

3. (a) FULL NAME
Nora Elizabeth Ambrose.

4. Sex 5. Color or race White 6.(a) Single, married, widowed, or divorced
Female Widowed

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 23, 1880
..... 8.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
64 4 20 hrs. min.

9. Birthplace Keymar, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Frank Zent.

13. Birthplace Carroll County, Md.

MOTHER 14. Maiden name Margaret Needy

15. Birthplace Smithsburg, Wash. Co., Md.

16. Informant Charles R. Ambrose

Address Thurmont, Md.

Burial 17. Date thereof March 13, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Blue Ridge

Location Thurmont, Md.

18. Funeral director M. L. Creager & Son

Address Thurmont, Md.

19. Mar. 13 1945 Anna M. Jones
(Date rec'd by registrar) Registrars
Pen Blanche Taylor

3. (b) Social Security Number
none.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Now 10 — 1944 to March 10, 1945
and that I last saw her alive on March 10 — 1945

Immediate cause of death Heart disease Organic
Bronchitis myosarditis 2 yrs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Jean H. Gray* M. D. or other *H. S.*

Address Thurmont, Md. Date signed 3/12/45

RECEIVED
APR 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

02875

131

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Frederick
County

Frederick-R. F. D. #5(Braddock)

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

Braddock

How long in hospital or institution?

3. (a) FULL NAME

DAISY SUSANNAH REBECCA BAST

4. Sex

5. Color or race

6.(a) Single, married, widowed, separated

F

W

S

6.(b) Name of husband or wife

B.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

September 8, 1874

8. AGE:

Years

Months

Days

If less than one day

70

6

7

hrs.

min.

9. Birthplace

Braddock-Frederick-Maryland
(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

12. Name

Simeon L. Bast

13. Birthplace

Frederick County Maryland

14. Maiden name

Ann J. Cutsail

15. Birthplace

Frederick County Maryland

16. Informant

Mrs. Elmegia B. Krantz

Address E. 2nd St., Frederick, Maryland

17. Burial

Date thereof 3/17/45

(Burial, exhumation, or removal of body)

(month) (day) (year)

Cemetery or cemetery

Mount Olivet Cemetery

Location

Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. 16 March 1945
(Date rec'd by registrar)

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

Frederick-R. F. D. #5

(If outside city or town limits, write RURAL and give nearest town)

Braddock

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th, 1945, at 7:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Duration

chronic Myocarditis - duration

Due to

benign ovarian tumor

Other conditions

Duration

5 years

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

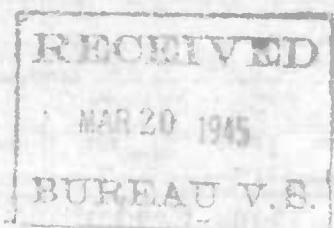
23. SIGNATURE Frank H. Hedges M. D.

M. D. or other

Address Frederick, Maryland Date signed 3-16-45

DEPARTMENT OF THE UNITED STATES POSTAL SERVICE

MAIL TO BE FORWARDED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16450

CERTIFICATE OF DEATH

02876
Reg. Dist. No. 140

1. PLACE OF DEATH:

County FrederickCity or town 2 Woodsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ross Melanchton Boller

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m 21. Married

6. (b) Name of husband or wife

Margaret S Weddle6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.)

Aug. 3. 1895

8. AGE:

Years

Months

Days

If less than one day

69 7 15

hrs. min.

9. Birthplace

Frederick Co Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Brush Factory

MOTHER FATHER

12. Name

Adrian Boller

13. Birthplace

Md.

14. Maiden name

Susan Smith

15. Birthplace

Md.

16. Informant

Mrs. Ross M Boller

Address

2 Woodsboro, Md.

17. Burial

Date thereof Mar 21. 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Hope

Location

2 Woodsboro, Md.

18. Funeral director

Burwell & Hartley

Address

2 Woodsboro, Md.

19. Date

Mar 18. 1945

(Date rec'd by registrar)

L G Parcell

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town 2 Woodsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-10-2776

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945 st. 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h.L.C.T. alive on dead March 19 1945Immediate cause of death Hangulation

DURATION

5 min.Due to Hangup

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3.18.45Where did injury occur? Woodsboro, Frederick, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Bar of houseMeans of injury Hangup Injured at work? No23. SIGNATURE R.W.B. Dignity Med Exp

M. D. or other

Address 5 Woodsboro, Md. Date signed 3.18.45



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02877

1. PLACE OF DEATH

County

Frederick

932

Registration Dist. No.

138

Village or City

St. Jamesville

No. Riggs Cottage Sanitarium 81 Ward

Length of residence in city or town where death occurred

5 yrs.

8 mos.

—ds.

How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME

Bettie S. Burns

(a) Residence: No.

Charleston, W. Va.

Ward.

Charles Town, W. Va.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Widowed

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

J. E. Burns

6. DATE OF BIRTH (month, day, and year)

Jan 28, 1856

7. AGE

Years
89

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BODKEEPER, etc.

Housewife

Date of onset

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)

1936

11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

Shepherdstown

West Va.

MOTHER / FATHER

13. NAME

F. Reason Shugart

14. BIRTHPLACE (city or town)

(State or country)

Penn.

Date of

Was there an autopsy?

No

15. MAIDEN NAME

Elizabeth Miller

16. BIRTHPLACE (city or town)

(State or country)

W. Va.

17. INFORMANT

Dr. J. Ed. Burns

(Address)

Stonewall 77-8a

18. BURIAL, CREMATION, OR REMOVAL

Place: Charles Town

Date: Mar. 30, 1941

19. UNDERTAKER

Magistrate T. Slider

(Address)

Charles Town, W. Va.

20. FILED

28 March, 1945

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Mar. 28

(Month)

(Day)

1945
(Year)

22. I HEREBY CERTIFY, That I attended deceased from

Aug 24, 1939, to Mar. 28, 1940.

I last saw her alive on Mar. 28, 1940; death is said to have occurred on the date stated above, at 1:30 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Chronic myocarditis
Central arteriosclerosis 1936?

Other Contributory Causes of Importance

General arteriosclerosis
Sensitivity

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No

If so, specify

(Signature) Harry J. McCall M. D.

(Address) St. Jamesville, W. Va.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset 1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
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Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset 1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4th

02878

131

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 10 years
Hospital, Institution, or street address where death occurred:
Frederick City Hospital
How long in hospital or institution?..... 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 423 North Bentz Street
(If rural, give LOCATION)
None
2.(a) If veteran, name war..... None

3. (a) FULL NAME
HETTIE ANN CARMACK

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
F	W	W		
6.(b) Name of husband or... Calvin P. Carmack				
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age..... years		
September 9, 1874				
8. AGE:	Years	Months	Days	If less than one day
	70	5	28	hrs. min.

9. Birthplace..... Mercersburg, Penna.
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business
12. Name..... James Briggs
13. Birthplace..... Mercersburg, Penna.

14. Maiden name..... Sarah
15. Birthplace..... Mercersburg, Penna.

16. Informant..... Mrs. Paul E. Himes
Address..... 423 N. Bentz St., Frederick, Md.

17. Burial
(Burial, cremation, or removal. Which)
Date thereof..... 3/10/45
(month) (day) (year)
Cemetery or crematory..... Frederick Memorial Park

Location..... Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son
Address..... Frederick, Maryland

19. Date rec'd by registrar..... 8 March 1945-
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 7th, 1945, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Alley 15 1945 to 1945 and that I last saw her alive on March 7th, 1945.

Immediate cause of death.....

Due to..... Carcinoma of liver
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operation..... Carcinoma of liver
Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. Parker M. D.

M. D. or other

Address..... Frederick, Maryland Date signed..... 3-8-45

RECEIVED

MAR 12 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13C

02879

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County..... Frederick

City..... Jefferson-Rural R. F. D. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.... 1 year

Hospital, Institution, or street address where death occurred:

Near Jefferson

How long in hospital or Institution?

3. (a) FULL NAME

DOROTHY MILLER CARRICK

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	M

6. (b) Name of husband or wife..... Edwin W. Carrick

7. Birth date of deceased (mo., day, yr.)..... July 18, 1916

8. (c) If alive, give age..... 44 years

8. AGE: Years	Months	Days	It less than one day
28	5	16	hrs. min.

9. Birthplace..... West Virginia

(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business.....

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Victoria Miller

15. Birthplace..... West Virginia

16. Informant..... Mrs. Lory See

Address..... Jefferson, Md. R. F. D. #1

17. Burial..... Date thereof..... 3/6/45

(Burial, cremation, or removal, which)..... (month) (day) (year)

Cemetery or crematory..... New Dale Cemetery

Location..... New Dale, West Virginia

18. Funeral director..... M. R. Etchison and Son

Address..... Frederick, Maryland

19. Date rec'd by registrar..... 5 March 1945

Registrar..... Elizabeth G. Heale

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City..... Jefferson-Rural R. F. D. #1

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Near Jefferson

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar 4 1945 at 4²⁰

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1944 to Mar 4 1945

and that I last saw her alive on Feb 26 1945

Immediate cause of death..... Tubercular Pulmonary

Tuberculosis with Cavitatio

Due to..... The infection

Due to.....

Other conditions..... Tuberculosis enteritis

at this infection

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... A. Lael & Linc M. D.

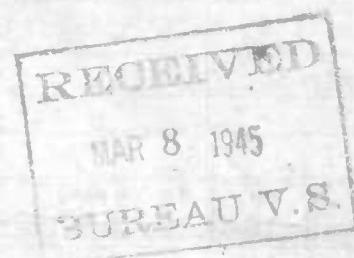
M. D. or other

Address..... Jefferson Md

Date signed..... 3/7/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

02880

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Lifetime

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or Institution?

10 days

3. (a) FULL NAME

GRACE ELIZABETH COMPER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife..... C. Elmer Compher

7. Birth date of deceased (mo., day, yr.)..... July 11, 1877

8. (c) If alive, give age..... 68 years

8. AGE: Years	Months	Days	If less than one day
67	8	12	hrs. min.

9. Birthplace..... Adamstown, Frederick Co., Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Marion S. Michael

13. Birthplace..... Frederick County, Maryland

14. Maiden name..... Alice Copeland

15. Birthplace..... Frederick County, Maryland

C. Elmer Compher

16. Informant.....

Address..... Adamstown, Maryland

17. Burial.....

(Burial, cremation, or removal, where) Date thereof..... March 25, 1945

(month) (day) (year)

Cemetery or crematory..... Mt. Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C. E. Cline & Son

Address..... Frederick, Maryland

19. 23 March 1945
(Date rec'd by registrar)Elizabeth G. Heals
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Adamstown
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 22 1945 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945 to March 22 1945

and that I last saw her alive on March 22 1945

Immediate cause of death..... Cardiac Arrest

DURATION

3 weeks

Due to..... Hypertension

10 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

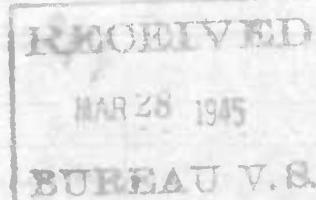
23. SIGNATURE.....

M. D. or other

Address..... Date signed 3.23.45

BUCK TO WESTWARD STATE GRAHAM

11700 NO RECAPTURE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

02881

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County..... Frederick
 City or town..... State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1/10/41

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since 1/10/41

3. (a) FULL NAME

John Connolly

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 23, 1887

8. AGE: Years	Months	Days	If less than one day
57	5	8	hrs. min.

8. Birthplace..... Washington, D.C.

(Town, county, and state)

10. Usual occupation..... Blacksmith

11. Industry or business

12. Name..... James Connolly

13. Birthplace..... Washington, D.C.

14. Maiden name..... Margaret Burke

15. Birthplace..... Ireland

16. Informant..... Deceased

Address.....

17. Burial (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Mt. Oliver Cemetery

Location..... Washington, D.C.

18. Funeral director..... W.P. Valley

Address..... Mt. Rainier Md.

19. (Date rec'd by registrar) 19.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No..... 3403 - 35th St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 31 10.45 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1941 to March 31 1945 and that I last saw him alive on March 31 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

5 Yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... J.B. Lynn

M. D. JOHNSON

Address..... State Sanatorium, Md. Date signed 3/31/45.

RECEIVED

APR 6 1945

BELL & WIGGINS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *P.D.*

02882

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yearsHospital, institution, or street address where death occurred:
31 East Fourth Street

How long in hospital or institution?

3. (a) FULL NAME

ALBERT FILMORE COOK

4. Sex <u>M</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>M</u>
--------------------	------------------------------	---

6.(b) Name of husband or wife Maggie Burdette7. Birth date of deceased (mo., day, yr.) October 19, 18706.(c) If alive, give age 69 years

8. AGE: Years <u>74</u>	Months <u>4</u>	Days <u>27</u>	If less than one day hrs. min.
----------------------------	--------------------	-------------------	---

9. Birthplace Nr. Jefferson-Frederick-Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Benjamin Cook13. Birthplace Frederick County Maryland14. Maiden name Elizabeth Stockman15. Birthplace Frederick County Maryland16. Informant Mrs. Maggie B. CookAddress 31 E. 4th St., Frederick, Md.17. Burial Date thereof 3/18/45
(Burial, cremation, or removal. Write)
(month) (day) (year)Cemetery or Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 16 March 1945 - Elizabeth Y. Heck
(Date rec'd by registrar)
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 East Fourth Street

(If rural, give LOCATION)

2.(a) If veteran, name war None3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th, 1945 at 4:15A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 8 1945 to March 16 1945and that I last saw him alive on March 13 1945Immediate cause of death Cerebral HemorrhageDue to Hypertensive Cardiac Vasculär DiseaseDuration 3 daysOther conditions (Include pregnancy within 8 months of death)Major findings of operations Date of op.Autopsy results

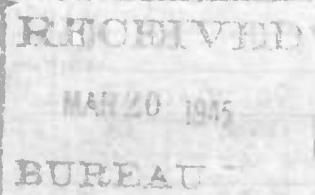
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date ofWhere did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)Means of injury Injured at work?23. SIGNATURE Howard W. Ash M.D. M. D. or otherAddress Frederick Md Date signed 3/16/45

RECEIVED BY THE STATE DEPARTMENT

RECORDED IN STAGBUT FILE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

CERTIFICATE OF DEATH

02883

Reg. Dist. No. 131

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred: 7 East Third Street
How long in hospital or institution?

3. (a) FULL NAME

FLORENCE MAY COOK

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	W

6. (b) Name of husband or wife George L. Cook
8. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 15, 1873

8. AGE: Years Months Days if less than one day
72 2 8 hrs. min.

9. Birthplace Nr. Jefferson-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name George S. Stockman
13. Birthplace Frederick County Maryland

MOTHER FATHER
14. Maiden name Alice F. Hargett
15. Birthplace Frederick County Maryland

16. Informant Miss Myrtle M. Cook
Address 7 E. 3rd St., Frederick, Md.

17. Burial Date thereof 3/26/45
(Burial, cremation, or removal which?) (month) (day) (year)

Cemetery or St. Pauls Lutheran Cemetery
Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

VS A15
19. Date rec'd by registrar 26 March 1945-
(Date rec'd by registrar) Elizabeth B. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 East Third Street
(If rural, give LOCATION) None
2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd, 1945 at 10:45 P.M.

21. CERTIFY that death occurred on the date above stated; that attended deceased from

File 28 1945 to Feb 28 1945 and that I last saw her alive on Feb 28 1945 to Mar 23 1945

Immediate cause of death Cerebral thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

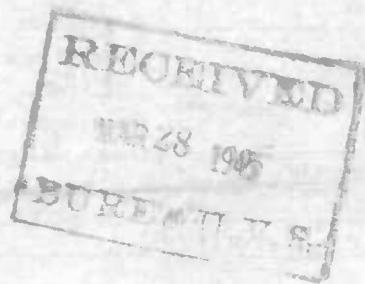
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Frederick, Maryland Date signed 3-26-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 14

62884
14

1. PLACE OF DEATH:

County Frederick

City or town Brunswick, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Schnauffers Hospital

How long in hospital or institution? 9 Days

3. (a) FULL NAME

Nettie Gertrude Crawford

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Divorced

6. (b) Name of husband or wife William Crawford

7. Birth date & deceased (m.e., day, yr.) November 17 1873

6. (c) If alive, give age 66 years

8. AGE: Years Months Days 11 less than one day
71 3 18 hrs. min.

9. Birthplace Martinsburg, W.Va.

(Town, county, and state)

10. Usual occupation House Keeping

11. Industry or business Home

12. Name Edward Thomas Kirby

13. Birthplace England

14. Maiden name Mary Elizabeth Wilson

15. Birthplace Bolivar, W.Va.

16. Informant Mrs Arlys Green

Address Bolivar, W.Va.

17. Burial Date thereof Mar 10 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harper Cemetery

Location Harpers Ferry, W.Va.

18. Funeral director J. H. Crackles

Address Bolivar, W.Va.

19. March 1, 1945
(Date rec'd by registrar)Emma Maitland
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W.Va. County Jefferson

City or town Bolivar, W.Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945, at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that deceased from

Feb 26, 1945, to March 6, 1945,

and that I last saw her alive on March 6, 1945.

Immediate cause of death

Cerebral Hemorrhage 10 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Dale el ep.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Dale et

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

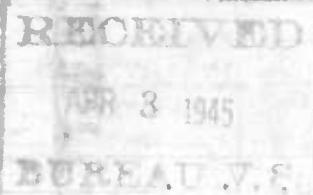
Means of Injury

Injured at work?

23. SIGNATURE Nellie Gertrude Crawford, M.D. or other

Address Bolivar, W.Va. Date signed March 6, 1945





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4th X

02885

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH

County Frederick
City or town 2 Woodsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pansy Irene Gruen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

<u>F</u> .	<u>M</u> .	<u>Widow</u>
------------	------------	--------------

6. (b) Name of husband or wife Frank J. Gruen

7. Birth date of deceased (mo., day, yr.)

July. 29. 1880

8. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
<u>64</u>	<u>7</u>	<u>20</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Own home12. Name John & V. Fox13. Birthplace Frederick Co. Md.14. Maiden name Sarah S. Fox15. Birthplace Frederick Co. Md.16. Interment Henry P. GruenAddress 2 Woodsboro Md.17. Burial Burial Date thereof Mar. 21. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or cemetery N.Y. HopeLocation 2 Woodsboro Md.18. Funeral director Burwell & HartleyAddress 2 Woodsboro Md.19. Date rec'd by registrar Mar. 21. 1945(Date rec'd by registrar) L. L. Powell
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town 2 Woodsboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19. 1945 at 1:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12. 1945 to March 19. 1945and that I last saw her alive on March 18. 1945

Immediate cause of death

Pneumonia, Cerebral
with heart trouble

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

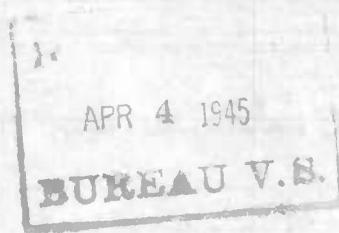
23. SIGNATURE Samuel P. Gruen

M. D. or other

Address Wolkesville, Md. Date signed 3/20/45

STANISLOV TROTSKY TO STATE DEPARTMENT

STANISLOV TROTSKY TO SPACERUSSIA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age & birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

02886

131

CERTIFICATE OF DEATH

Reg. Dist. No....

FILM NO. G 94 MAY 11 1945

1. PLACE OF DEATH:

County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

40 years

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

40 East Seventh Street

How long in hospital or institution?.....

3. (a) FULL NAME

CORA VICTORIA DANNER

4. Sex

Female	5. Color or race	6.(a) Single, married, widowed, or divorced
	White	Widowed

6.(b) Name of husband or wife

Harry S. Danner

7. Birth date of deceased (mo., day, yr.)

July 19, 1871 1870

8. AGE:

Years	Months	Days	If less than one day
74	73	8	7
			hrs. min.

9. Birthplace.....

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name..... James M. Mull

13. Birthplace..... Loudon County, Virginia

14. Maiden name..... Cornelia Catherine Whipp

15. Birthplace..... Frederick County, Maryland

16. Informant..... Harry F. Danner

Address..... Frederick, Maryland

17. Burial..... Date thereof..... March 29, 1945

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C. E. Shire & Son

Address..... Frederick, Maryland

19. Date rec'd by registrar..... 27 March 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No..... 40 East Seventh Street (If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 26 1945 at 5:35 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

September 19, to March 26, 1945

and that I last saw her alive on March 26, 1945

Immediate cause of death..... Cerebral Hemorrhage

Due to..... Hypertension Arterio-

Vascular Disease

Due to.....

Other conditions..... Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

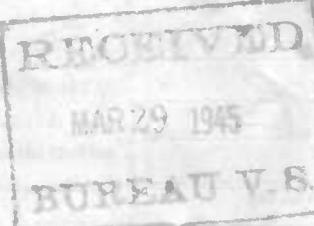
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Edward W. Ash M.D.

M. D. or other

Address..... Frederick, Md. Date signed..... 31, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

02887

139

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Sabillasville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Luther Delawter

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife..... Addie Belle Lantz

7. Birth date of deceased (mo., day, yr.) March 5, 1858

8. AGE: Years Months Days If less than one day
87 0 15 hrs. min.

9. Birthplace..... Foxville, Frederick Co., Md

(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Farming

12. Name..... George W. Delawter

13. Birthplace..... Foxville, Md.

14. Maiden name..... Isabelle Brown.

15. Birthplace..... Foxville, Md.

16. Informant..... John Delawter

Address..... Sabillasville, Md.

17. Burial Date thereof March 23, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... United Brethren

Location..... Thurmont, Md.

18. Funeral director..... M. L. Creager & Son.

Address..... Thurmont, Md.

19. Date rec'd by registrar..... Mar 22 1945
 (Date rec'd by registrar) 6 E. Shields
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Foxville - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION) no

2.(a) Is veteran, name war.....

3. (b) Social Security Number..... none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 20, 1945, IQ: I5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 [Signature] 1942, to Mar. 20, 1945
 and that I last saw him alive on Mar. 20, 1945

Immediate cause of death.....

Report due to [Signature]
 Chronic Myocarditis
 3 yrs

Due to.....

Due to.....

Other conditions..... Old age debility

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... James T. Gray M.D.

M. D. or other

Address..... Belmont Md. Date signed Mar 22 1945

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *No. 2*

CERTIFICATE OF DEATH

Reg. Dist. No. *131**62888*

1. PLACE OF DEATH:

County *Frederick Co., Md.*
City or town *Fredericksburg*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

3. (a) FULL NAME

CHARLES BOYD DIVERS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *April 20, 1920*
6.(c) If alive, give age..... years

8. AGE: Years *24* Months *10* Days *28* If less than one day
hrs. *0* min. *0*

9. Birthplace *Wirtz, Franklin Co., Va.*
(Town, county, and state)10. Usual occupation. *Farmer*

11. Industry or business

12. Name *Irvin Lee Divers*
13. Birthplace *Salem, Va.*14. Maiden name *Geneva Powell*15. Birthplace *Salem, Va.*16. Informant *Irvin Lee Divers*Address *Salem, Va.*17. Burial Date thereof *3/21/45*
(Burial, cremation, or removal, where?) *accrest* Date of *3. 18. 45*Cemetery or columbarium *Oak Hill*Location *Near Salem, Va.*18. Funeral director *Raymond F. Wright*Address *Elmwood Bridge, Md.*19. *19 March 1945* Elizabetta L. Heck
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Fredericksburg*
City or town *Fredericksburg*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *107 Any Rd. S.D.*
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 18 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him *dead* *alive* on *March 18 1945*

Immediate cause of death

*Compound fracture
of skull* DURATION
15 min.

Due to *Shock, Hemorrhage*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *3. 18. 45*
Where did injury occur? *177 Pleasant Frederick Rd.* (City or town) (County) (State) *Route 26*

Injured at home, farm, industry, public place (where?)

Means of injury *automobile* Injured at work? *no*23. SIGNATURE *R. W. Divers* M. D. or otherAddress *Frederick, Md.* Date signed *3. 19. 45*

RECEIVED
MAR 20 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

02889

131

Reg. Dlat. No.....

1. PLACE OF DEATH:

County FrederickCity or town Frederick City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, Institution, or street address where death occurred: Frederick City HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

Euler M. William - Edward

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Viola Wetzel Euler6. (c) If alive, give age 60 years

7. Birth date of deceased (mo. day, yr.)

August 30, 1904

8. AGE:

406DaysIt less than one dayhrs.min.

9. Birthplace

Emmitsburg, Fred's Co., Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Md. State Sanatorium

MOTHER FATHER

Joseph EulerEmmitsburg, Md.Nettie StarbroughEmmitsburg, Md.Mrs. William EulerLantz, Md.BurialBurial, cremation, or removal. Which?Date thereof Mar 14, 1945(month) (day) (year)United BrethrenCemetery orHarmont, Md.LocationM. L. Creager & SonFuneral directorThurmont, Md.AddressElizabeth G. Hech(Date rec'd by registrar)Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1945 to March 11, 1945and that I last saw him alive on March 11, 1945

Immediate cause of death

Acute PericarditisDue to MyocardiaDue to Chronic MyocarditisOther conditions Old

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work None23. SIGNATURE A. Gordon Pearce, M.D.

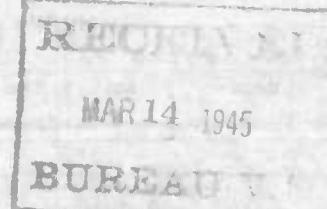
M. D. or other

Address Frederick, Md. Date signed 3/11/45

MEMORANDUM FOR THE CHIEF OF STAFF, UNITED STATES AIR FORCE

RECORDED IN THE OFFICE OF THE CHIEF OF STAFF
MARCH 14, 1945

COLLECTIVE SECURITY



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-B

02890

CERTIFICATE OF DEATH

Reg. Dist. No. 140

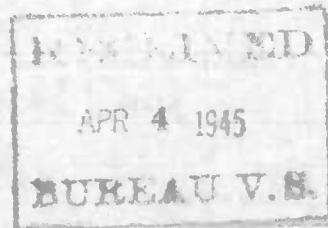
1. PLACE OF DEATH:
County Frederick
City or town New Midway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town New Midway
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Ernest Walter Flanagan.
4. Sex Male Color or race White Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Leafy Darkis
7. Birth date of deceased (mo., day, yr.) September 23, 1875
8. AGE: Years Months Days If less than one day
69 5 20 hrs. min.
9. Birthplace Utica Mills Frederick Co. Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Farmer
FATHER 12. Name John F. Flanagan
13. Birthplace Utica Mills, Md.
MOTHER 14. Maiden name Minerva Snook.
15. Birthplace Creagerstown, Md.
16. Informant Mrs. Ernest Flanagan
Address New Midway, Md.
17. Burial Date thereof March 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Hope Cemetery
Location Woodsboro, Md.
18. Funeral director M. L. Creager & Son
Address Thurmont, Md.
19. Mar. 15 1945 (Date rec'd by registrar)

L E Powell
Registrar

3. (b) Social Security Number none
MEDICAL CERTIFICATION
20. DATE OF DEATH March 13, 1945, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1944 to March 11 1945 and that I last saw h. in alive on March 4 1945
Immediate cause of death Pulmonary Tuberculosis
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings or operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where)?
Means of injury Injured at work?
23. SIGNATURE James Wray M.D.
J. Wray M.D.
Address Thurmont, Md. M. D. or other
Date signed Mar. 15 1945



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

Reg. Dist. No. 62891

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Frederick

County.....

City or town..... State Sanatorium, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12/9/39

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since 12/9/39

3. (a) FULL NAME

David Flynn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1902

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

42

3

7

....hrs.min.

9. Birthplace..... Meadows, Maryland

(Town, county, and state)

10. Usual occupation..... Steam Fitter

11. Industry or business

12. Name..... George K. Flynn

13. Birthplace..... Unknown

14. Maiden name..... Ida Pinkney

15. Birthplace..... Maryland

16. Informant..... Deceased

Address

17. Burial, cremation, or removal. Which? Burial Date thereof December

(month) (day) (year)

Cemetery or crematory..... Greenlawn

Location..... W.W. Chambers

18. Funeral director..... W.W. Chambers

Address

19. (Date rec'd by registrar) 3/29 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

187-05-3832

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 29

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 1939, to March 29, 1945, and that I last saw him alive on March 29, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

7 Yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... D. Flynn

M. D. FLYNN

Address..... State Sanatorium, Md. Date signed 3/20/45

RECEIVED TO THE SECRETARY OF STATE

17 APR 1945

NO REPORT

RECEIVED

APR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02892

M

CERTIFICATE OF DEATH

Reg. Dist. No. 139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



VS A15

1. PLACE OF DEATH: Frederick
County.....
City or town. State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Jan. 26, 1943
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Since Jan. 26, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County.....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 S. Fulton Ave.
(If rural, give LOCATION)

3. (a) FULL NAME Harry M. Forrest
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) July 1, 1895
8. AGE: Years Months Days If less than one day
49 8 11 hrs. min.
9. Birthplace Brunswick, Md.
(Town, county, and state)
10. Usual occupation Fireman
11. Industry or business
12. Name Thomas Forrest
13. Birthplace Maryland
14. Maiden name Winnie Gaven
15. Birthplace Maryland
16. Informant Deceased
Address

17. Burial Date thereof 3/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or cemetery Mt. Olivet
Location Frederick Rd., Balto., Md.

18. Funeral director John Cowan & Son
Address Hollins St., Balto., Md.
3/13/45
(Date rec'd by registrar)

2. (a) If veteran, name war
3. (b) Social Security Number 220-09-8205

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 1943, to Mar. 12 1945,
and that I last saw him alive on March 12 1945.

Immediate cause of death Pulmonary Tuberculosis
DURATION 3 Yrs.

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

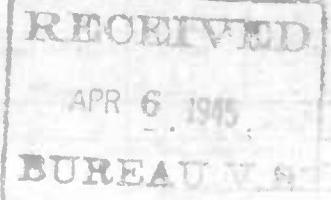
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.B. Lynn
M. D. of MD
Address State Sanatorium, Md. Date signed 3/13/45

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

02893
P 31
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 yr.

Hospital, Institution, or street address where death occurred:

107 Pennsylvania Ave

How long in hospital or institution?.....

3. (a) FULL NAME

Frederick Fox

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

YY Widowed

6. (b) Name of husband or wife.....

Matilda Smith

7. Birth date of deceased (mo., day, yr.)

Nov 25 1851

8. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day
93 3 4 hrs. min.

9. Birthplace.....

Frederick Co. Md
(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

John Fox

Frederick Co. Md

Mary Biggs

Frederick Co. Md

David R. Fox

107 Pennsylvania Ave Fred City

Burial Date thereof March 4 1940

Cemetery or crematory Mt. Hope

Location Woodsboro Md

E. G. Barton

Address Walkersville Md

19. 2 March 1945 - Elizabeth G. Hecker

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Woodsboro Md (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 1st 1940 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20 1940 to March 1 1940

and that I last saw her alive on March 1 1940

Immediate cause of death.....

Hypostatic pneumonia

DURATION

3 days

Due to: Fracture of left thigh

Feb 20

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

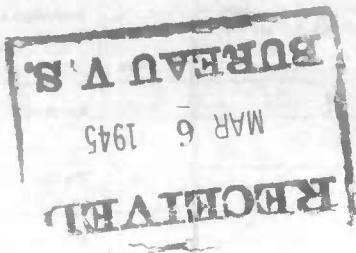
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... B. O. Thomas

M. D. or other

Address..... Frederick Md Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

02894

131

Reg. Dist. No.....

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
123 East Patrick Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 East Patrick Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME
CORA OLELVIA FRY

3. (b) Social Security Number
None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>S</u>
-----------------	---------------------------	--

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 16, 1870
8. (c) If alive, give age years

8. AGE: Years <u>75</u>	Months <u>0</u>	Days <u>4</u>	If less than one day hrs. min.
-------------------------	-----------------	---------------	--

9. Birthplace Jefferson-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Isaac N. Fry

13. Birthplace Virginia

14. Maiden name Mary E. Shaff

15. Birthplace Maryland

16. Informant Miss Daisy C. Fry

Address 123 E. Patrick St., Frederick, Md.

17. Burial Date thereof 3/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or St. Pauls Lutheran Cemetery

Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 22 March 1945 (Date rec'd by registrar) Elizabeth G. Heck (Signature)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th, 1945 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her DEAD March 20th, 1945.

Immediate cause of death Coronary
oedema

Due to arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

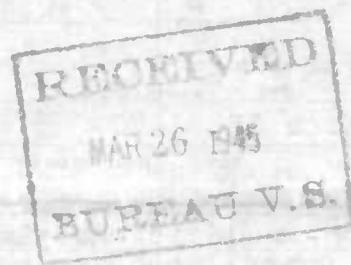
Means of injury

Injured at work?

23. SIGNATURE P. W. Baer (initials used Ex.)

M. D. or other

Address Frederick, Maryland Date signed 3-21-45



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

02895

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick
City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Lifetime

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

South Market Street

How long in hospital or institution?.....

3. (a) FULL NAME

OWEN FRY

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Mrs. Katie Fry

7. Birth date of deceased (mo., day, yr.)..... November 2, 1886

8. AGE: Years	Months	Days	It less than one day
58	4	21	hrs. min.

9. Birthplace..... Frederick County, Maryland
(Town, county, and state)

10. Usual occupation..... Merchant

11. Industry or business.....

12. Name..... Richard Fry

13. Birthplace..... Frederick County, Maryland

14. Maiden name..... Helen Stine

15. Birthplace..... Frederick County, Maryland

16. Informant..... Mrs. Katie Fry

Address..... Frederick, Maryland

17. Burial..... Date thereof..... Mar. 26, 1945
(Burial, cremation, or removal - Which?) (month) (day) (year)

Cemetery or cemetery..... Mt. Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C. E. Cline & Son

Address..... Frederick, Maryland

19. Date rec'd by registrar..... March 24, 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No..... South Market Street (If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 23, 1945 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. l. J. alive on March 23, 1945

Immediate cause of death..... Acute alcoholism

Due to..... Chronic alcoholism

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

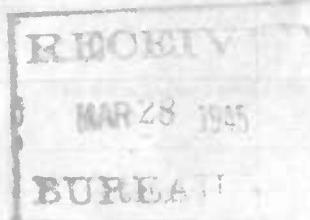
Means of injury..... DR. R. W. BAER Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Frederick DR. R. W. BAER MEDICAL EXAMINER Date signed..... 3.25.45

RECORDED IN THE LIBRARY OF THE STATE OF ILLINOIS

RECORDED IN THE LIBRARY OF THE STATE OF ILLINOIS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131

CERTIFICATE OF DEATH

Reg. Dist. No. 02896
131

1. PLACE OF DEATH:

County FredrickCity or town Fredrick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day.

Hospital, institution, or street address where death occurred:

Fredrick City HospitalHow long in hospital or institution? 1 day.

3. (a) FULL NAME

Patrick Gallagher

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MalewhiteMarried

8. (b) Name of husband or wife

Mary Mullin

7. Birth date of deceased (mo., day, yr.)

May 17 18988. (c) If alive, give age 43 years

8. AGE:

Years

Months

Days

If less than one day

47

10

14

hrs. min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

B&O R.R. Brakeman

11. Industry or business

John Gallagher

12. Name

Ireland

13. Birthplace

unknown

14. Maiden name

MOTHER

John Gallagher

15. Birthplace

unknown

16. Informant

mrs Mary Mullin Gallagher

Address

Phila. Penn.

17. Removal

Removal

(Burial, cremation, or removal. Which?)

Date thereof April 1 1945

(month) (day) (year)

Cemetery or crematory

Philadelphia Pa.

Location

Philadelphia Pa.

18. Funeral director

L. H. Fette & Sons

Address

Brunswick Maryland

19. April 1 - 1945

(Date rec'd by registrar)

Elizabeth J. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn.

County

City or town Phila.

County

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5407 Woodlawn Ave

County

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

dead 19 to 10 and that I last saw h.f.m. alive on March 31 1945

Immediate cause of death

Frosture of skull

DURATION

1 dayDue to Fall from hedge

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

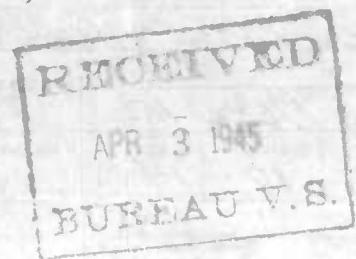
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3.30.45Where did injury occur? Brunswick, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) 1st fl. bridgeMeans of injury fall Injured at work? yes23. SIGNATURE R.W. Barr. Dept. Med. Ex. M. D. or otherAddress Fredrick, Md. Date signed 3.31.45

STANDARD TELEGRAPHIC STATE WIRELESS

TELETYPE TRANSMITTER CARD



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

CERTIFICATE OF DEATH

02897

131

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		
County	Frederick,	
City or town	Frederick	
(If outside city or town limits, write RURAL and give nearest town)		
Lifetime		
Hospital, institution, or street address where death occurred:		
222 West Patrick Street		
How long in hospital or institution?		

3. (a) FULL NAME		
LEWIS BENEDICT GANNON		
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married
6.(b) Name of husband or wife..... Cora Garrett Gannon		
7. Birth date of deceased (mo., day, yr.) November 8, 1886		
8. AGE: Years Months Days If less than one day		
58	4	14 hrs. min.
9. Birthplace..... Frederick, Maryland (Town, county, and state)		
10. Usual occupation..... Machinist		
11. Industry or business.....		
FATHER	12. Name..... William Edward Gannon	
	13. Birthplace..... Frederick, Maryland	
MOTHER	14. Maiden name..... Alice A. Buckles	
	15. Birthplace..... Indianapolis, Indiana	
16. Informant..... Mrs. Lewis Gannon		
Address..... Frederick, Maryland		
17. Burial..... Date thereof..... Mar. 22 1945 (Burial, cremation, or removal, where?)		
Mt. Olivet Cemetery		
Cemetery or cemetery		
Location..... Frederick, Maryland		
18. Funeral director..... C. E. Cline & Son		
Address..... Frederick, Maryland		
19. Date rec'd by registrar..... Elizabeth G. Hecke		
(Date rec'd by registrar)		

2. USUAL RESIDENCE (HOME) OF DECEASED:		
(For newborn infants give residence of mother)		
State	Maryland County	
City or town	Frederick	
(If outside city or town limits, write RURAL and give nearest town)		
Street No..... 222 West Patrick Street		
(If rural, give LOCATION)		
None		

2.(a) If veteran, name war.....

3. (b) Social Security Number

577-03-5709

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 21 1945 to Mar. 22 1945 and that I last saw him alive on Mar. 21 1945

Immediate cause of death..... Hernia of the abdomen 48 hrs. DURATION

Due to.....

Due to.....

Other conditions..... Hypertension 1 med

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

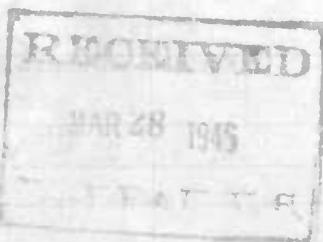
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE M. D. or other

Date signed

VS A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-2

CERTIFICATE OF DEATH

0289831
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
City or town near Walkersville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Reginald Eugene Ligeous

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

w

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

April 22, 1942

8. AGE:

Years

Months

Days

It less than one day

2

11

6

hrs.

min.

9. Birthplace

Leesburg Fred Co, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

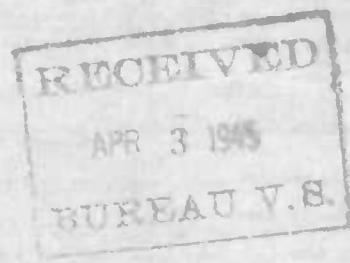
12. Name Ray F. Ligeous

MOTHER

13. Birthplace Thurmont Fred Co.

14. Maiden name

15. Birthplace Pauline E. Putman



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No.

02899

139

1. PLACE OF DEATH: **Frederick**
 County
 City or town **State Sanatorium, Maryland**
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **Since 3/19/45**
 Hospital, institution, or street address where death occurred: **Maryland Tuberculosis Sanatorium**
 How long in hospital or institution? **Since 3/19/45**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County
 City or town **Baltimore** (If outside city or town limits, write RURAL and give nearest town)
 Street No. **530 W. Franklin** (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME
Hom Gin (Tom Lee)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Yellow	Single

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **January 2, 1875** years

8. AGE: Years	Months	Days	If less than one day
70	2	18	hrs. min.

9. Birthplace..... **California**
(Town, county, and state)10. Usual occupation..... **Kitchen work**

11. Industry or business

FATHER	12. Name.....	Hom
	13. Birthplace	California

MOTHER	14. Maiden name.....	?
	15. Birthplace	?

16. Informant..... **Deceased**

Address

17. Burial..... Date thereof..... **3/23/45**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery **XX Lorraine**
 Location **Baltimore, Md.**18. Funeral director..... **M. L. Creager & Son**
 Address **Thurmont, Md.**19. (Date rec'd by registrar) **3/20/45** Registrarsignature

MEDICAL CERTIFICATION

20. DATE OF DEATH **March 20** 19 **45** at **8:30 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 19** 19 **45** to **March 20** 19 **45** and that I last saw him alive on **March 20** 19 **45**Immediate cause of death **Pulmonary Tuberculosis** DURATION **4 Mos.**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **JL Lee** M. D. **XX**Address State Sanatorium, Md. Date signed **3/21/45**

RECEIVED

APR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information clearly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

029000131
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederickor town Walkersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 87 yrs

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Ida Mae Grubill4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or T. Frank Grubill7. Birth date of deceased (mo., day, yr.) May 30, 1857

6. (c) If alive, give age years

8. AGE: Years 87 Months 9 Days 18 If less than one day

hrs. min.

9. Birthplace Walkersville, Fred Co, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Eva Barrick13. Birthplace Frederick Co.14. Maiden name Sophia Jones15. Birthplace Frederick Co.16. Informant Miss Bertha GrubillAddress Walkersville17. Burial Burial Date thereof Mar. 21, 1945

(Burial, cremation, or removal, whence?) (month) (day) (year)

Cemetery or crematory Mt. OlivetLocation Frederick, Md.18. Funeral director G. C. BurtonAddress Walkersville19. (a) Date rec'd by registrar 19 March 1945 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederickor town Walkersville (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 7:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937 1945, to March 18 1945, and that I last saw her alive on March 17 1945.Immediate cause of death AphexyDue to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

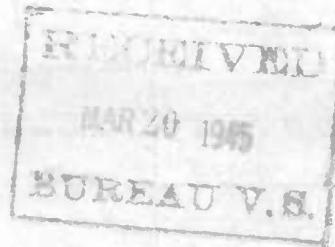
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work? 23. SIGNATURE Carroll E. Costiday M. D. or other Address Walkersville, Md. Date signed 3/29/45

RECEIVED IN THE LIBRARY OF THE STATE DEPARTMENT

RECEIVED BY ADAMITZ



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

02901
Reg. Dist. No. 144

1. PLACE OF DEATH:

County *Fredrick*
 City or town *Thurmont*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pauline M. Grable.

4. Sex

Female White Married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

John M. Grable

6. (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.)

December 3, 1923.

8. AGE:

Years 21	Months 3	Days 1	If less than one day hrs. min.
----------	----------	--------	---

9. Birthplace

Scranton, Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Joseph Smelik

12. Name

Joseph Smelik

13. Birthplace

Scranton, Pa.

14. Maiden name

Katie

15. Birthplace

Scranton, Pa.

16. Informant

John M. Grable

Address

Thurmont, Md.

17. Burial

Date thereof March 7, 1945

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

United Bethesda

Location

Thurmont, Md.

18. Funeral director

M. L. Grable & Son

Address

Thurmont, Md.

19. March 6, 1945

(Date rec'd by registrar)

Anna M. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Thurmont (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

7th

3. (b) Social Security Number

213-20-8558

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4 1945 34A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 18 1945 to Mar. 4 1945

and that I last saw her alive on Mar. 1 1945

Immediate cause of death

Acute Endocarditis

Due to Chronic Endocarditis

Complication of

Due to Scarlet Fever

DURATION

2 wks

15 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

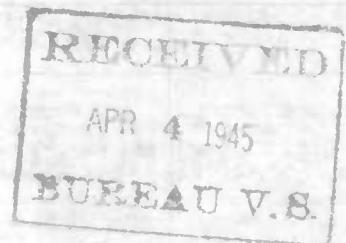
Means of injury

Injured at work?

23. SIGNATURE

Katherine May M. D. or other

Address Thurmont, Md. Date signed 3/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

02902

CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH:

County

City or town

Frederick
Adamsville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Alberta Green

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lawrence E Green

7. Birth date of deceased (mo., day, yr.)

Aug. 12 - 1875

(b) If alive, give age 65 years

8. AGE:

Years Months Days If less than one day

69

7

6

hrs

min.

9. Birthplace

Thurmont Frederick MD

(Town, county, and state)

10. Usual occupation

Housewife

Lawrence E Green

Martin Miller

Thurmont Frederick MD

14. Maiden name

Lawrence E Green

Adamsville MD

Burial

Date thereof March 16-1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Limestone Cemetery

Location Thurmont MD

M. & G. Green Son

Address Thurmont MD

Means of Injury

Injured at home, farm, industry, public place (where?)

Injured at work?

Injury

Address Mt. airy, Md

Date signed 3/13/45

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Frederick

City or town

Adamsville

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 13 1945

I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1940 to March 13, 1945

and that I last saw her alive on March 13, 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

1da

Due to Arterio-Sclerosis

? yrs

Due to Hypertension

? yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none Date of op.

Autopsy results

none Date of

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

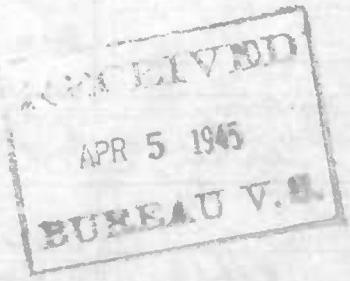
Means of injury Injured at work?

Signature M. D. or other

Address Mt. airy, Md Date signed 3/13/45

(Date rec'd by registrar)

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK,
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9th

02903

144

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
 County..... Frederick
 City or town..... Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 20 years
 Hospital, institution, or street address where death occurred:

 Now long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... West Main
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... no

3. (a) FULL NAME
 Dorothy Myrtle Harbaugh.

3. (b) Social Security Number
 none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... William F. Harbaugh
 6.(c) If alive, give age..... 64 years

7. Birth date of deceased (mo., day, yr.)
 May 20, 1884

8. AGE: Years Months Days If less than one day
 60 9 26 hrs. min.

9. Birthplace..... Lantz, Frederick Co., Md.
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Housewife.

12. Name..... Daniel Manahan

13. Birthplace..... Lantz, Md.

14. Maiden name..... Ellen Buhrman.

15. Birthplace..... Lantz, Md.

16. Informant..... William Harbaugh

Address..... Thurmont, Md.

17. Burial..... Date thereof..... Mar. 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Blue Ridge
 Location..... Thurmont, Md.

18. Funeral director..... M. L. Creager & Son
 Address..... Thurmont, Md.

19. March 17, 1945
 (Date rec'd by registrar) Anna M. Jones
 Registrar
 Geo. R. S. Eycles

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 16, 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that attended deceased from July 15, 1942, to March 16, 1945, and that I last saw her alive on March 15, 1945.

Immediate cause of death..... Heart disease, chronic +
 Gallopericarditis, organic +
 Duration..... 3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

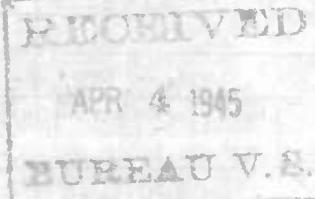
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. Ernest Gray
 M. D. or other
 Address..... Thurmont, Md.

Date signed..... Mar. 16, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-1

02984

CERTIFICATE OF DEATH

131

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred:

100 West Fourth Street

How long in hospital or institution?

3. (a) FULL NAME

ANNA REBECCA HARGETT

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>W</u>
--------------------	------------------------------	--

8. (b) Name of husband or wife George F. Hargett7. Birth date of deceased (mo., day, yr.) September 24, 18688. AGE: Years 76 Months 5 Days 20 If less than one day
hrs. min.9. Birthplace Loudoun County Virginia
(Town, county, and state)

At Home

10. Usual occupation.

11. Industry or business

12. Name Jacob Hartman13. Birthplace Loudoun County Virginia14. Maiden name Alice Virtz15. Birthplace Loudoun County Virginia16. Informant Mrs. Lester B. BartlettAddress 100 W. 4th St., Frederick, Md.17. Burial Date thereof 3/7/45(Burial, cremation, or removal, which)
Cemetery or embalmer Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. Date rec'd by registrar Elizabeth G. Hatch
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County FrederickCity or town Buckeystown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th, 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30th 1944 to March 2d 1945

and that I last saw her alive on March 2d, 1945

Immediate cause of death Chronic myocarditisDURATION 2 mos.

Due to.....

Due to.....

Other conditions Bronchitis - capillary

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

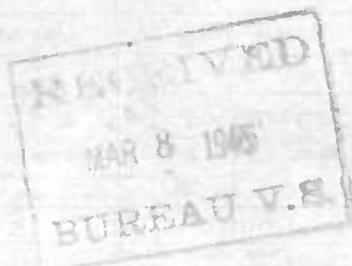
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE C. H. Conley, M.D.
C. H. Conley, M.D. or otherAddress Frederick, Maryland Date signed 3-5-45

VSA15

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AS A PROOF OF TRANSMISSION



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-2905

CERTIFICATE OF DEATH

02905

131

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Frederick

City Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred: Yellow Springs

How long in hospital or Institution?

3. (a) FULL NAME

LUCY ELLEN HARRIS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	W

8. (b) Name of husband or
William H. Harris

7. Birth date of
deceased (mo., day, yr.) November 30, 1856
6. (c) If alive, give age years

8. AGE:	Years	Months	Days	It less than one day
	88	4	19	hrs. min.

9. Birthplace Wolfsville-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name John W. Lewis

13. Birthplace Frederick County Maryland

Mother FATHER Maria Meisinger

14. Maiden name

15. Birthplace Frederick County Maryland

18. Informant Roy McK. Harris

Address 805 Motter Ave., Frederick, Md.

17. Burial Date thereof 3/21/45
(Burial, cremation, or removal. Which)

Cemetery or removal Pleasant Hill Cemetery

Location Frederick, Maryland R.F.D. #3

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. Date rec'd by registrar Elizabeth Hels

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)

Street No. Yellow Springs
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18, 1945, to April 19, 1945,

and that I last saw her alive on March 18, 1945.

Immediate cause of death

Lordin Pettman

Died My Lordin

DURATION 6 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. H. Hels M. D.

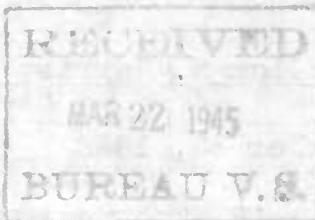
M. D. or other

Address Frederick, Maryland Date signed 3-20-45

BUA 10 DEPARTMENT STATE-WASHIN

BUA 10 DEPARTMENT STATE

RECEIVED MAR 22 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-10

CERTIFICATE OF DEATH

0299631
Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 mosHospital, institution, or street address where death occurred: South St. Frederick Md.

How long in hospital or institution?

3. (a) FULL NAME Eugene Buchanan Holt4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary C Fogle Holt7. Birth date of deceased (mo., day, yr.) April 19 - 1856 6. (c) If alive, give age years8. AGE: Years 88 Months 0 Days 8 If less than one day hrs. min.9. Birthplace Lovington Fred Co N.J. (Town, county, and state)10. Usual occupation Retired11. Industry or business Benzinger Holt12. Name Benjamin Holt13. Birthplace Lovington Md14. Maiden name Harriett Hopper15. Birthplace Lovington Md16. Informant Mrs Clarence ShamblerAddress 108 E South St Frederick Md17. Burial Date thereof March 14-45
(Burial, cremation, or removal. Which?) Date thereof
(month) (day) (year)Cemetery or Lovington CemeteryLocation Lovington Md18. Funeral director M. L. Deagan HaganAddress Thurmont Md19. (a) Date March 1945- (Date rec'd by registrar) Elizabeth G. Hecks:
Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State MD County FrederickOther town Lovington (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war no3. (b) Social Security Number no

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 45 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3-45 to 3/11, and that I last saw him alive on about 3/10/45.Immediate cause of death Ch. Cardis - Renal VasculitisDue to diseaseDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Eliz. Bourse Jr. M. D. or other Address Frederick Md Date signed 3-12-45

RECEIVED

MAR 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

02907

Reg. Dist. No. 144

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Frederick

County

Thurmont - rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clara B. Hoover.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

W. Roy Hoover

7. Birth date of deceased (mo., day, yr.)

June 10, 1894

6. (c) If alive, give age

52

years

8. AGE:

Years

Months

Days

11 less than one day

50

9

15

hrs.

min.

9. Birthplace

Baltimore County, Md.

(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

Home.

MOTHER FATHER

12. Name

John W. Bowie

13. Birthplace

Baltimore County, Md.

14. Maiden name

Helen —

15. Birthplace

Baltimore Co., Md.

16. Informant

W. Roy Hoover.

Address

Thurmont, Md.

17. Burial

Date thereof Mar. 28, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

New Oakland

Location

Carroll County, Md.

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Md.

19. Mar. 27 1945

(Date rec'd by registrar)

Anna M. Jones

Registrar

Per blonde S. Eyer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Frederick

City or town Thurmont. - rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

no

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22nd 1945 to Mar 25 1945

and that I last saw her alive on Mar 25 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to Acute nephritis

6 hrs

Due to Hypertension

0

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Morris A. Brichy

M. D. or other

Address

Thurmont, Md.

Date signed 3/27/45

R.D.C.

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B1A

02908

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
Frederick
County Frederick-Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 18½ Hours

3. (a) FULL NAME

DAISY HURD

4. Sex F	5. Color or race C	6. (a) E married, widowed, or divorced M
----------	--------------------	---

6. (b) Name of husband Oscar Hurd

7. Birth date of deceased (mo. day, yr.) January 1, 1902

8. AGE: Years 43	Months 2	Days 30	It less than one day hrs. min.
------------------	----------	---------	-------------------------------------

8. Birthplace Nr. Gaithersburg-Montgomery Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name William T. Scott

13. Birthplace Baltimore, Maryland

14. Maiden name Louise E. Johnson

15. Birthplace Baltimore, Maryland

16. Informant Oscar Hurd

Address 106 W. 6th St., Frederick, Md.

17. Burial Date thereof 4/2/45

(Burial, cremation, or removal; which) Fairview Cemetery

Cemetery or ~~crematory~~ Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. Date record by registrar 2 April 1945

Elizabeth G. Heile

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 West Sixth Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st, 1945 at 6:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945 to March 31 1945 and that I last saw her alive on March 30 1945

Immediate cause of death Cardiac decompenstation

DURATION 2 days

Due to Cardiac Vasculitis Venae

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Ante mortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

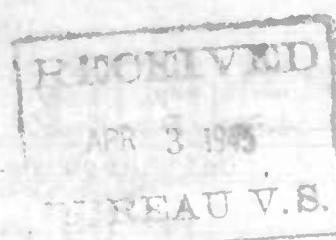
23. SIGNATURE H. Lawrence Faherty MD

M. D. or other

Address Frederick, Md. Date signed 331-45

TO SAKH NO. TICHTKATRI STATE GHATIKA

RECEIVED APR 3 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13B

02999

CERTIFICATE OF DEATH

Reg. Dlat. No. 131

1. PLACE OF DEATH
Frederick
County Doubs
City or town

(If outside city or town limits, write RURAL and give nearest town)

6 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

CHARLES ORLANDO HURLEY

4. Sex M	5. Color or race W	6. (a) Single, married, widowed, or divorced S
-------------	-----------------------	---

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)
February 18, 18918. AGE: Years Month Day If less than one day
54 0 23 hrs. min.9. Birthplace Washington-District of Columbia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James W. Hurley
13. Birthplace Virginia

MOTHER
14. Maiden name Alice Smith
15. Birthplace Kentucky

18. Informant Mrs. Vernon L. Faulkner
Address Doubs, Maryland

17. Burial Date thereof 3/14/45
(Burial, cremation, or removal, where)
(month) (day) (year)

Cemetery or crematory Congressional Cemetery
Location Washington, D. C.

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. Date rec'd by registrar 12 March 1945
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Doubs

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th, 1945 at 4:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h... dead Mar 11, 1945

Immediate cause of death Coronary occlusion

Due to Asthma

Due to Pulmonary TBC

healed

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

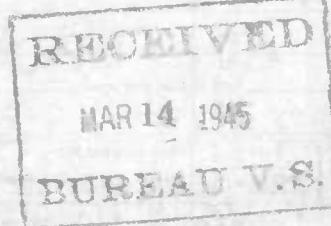
Injured at home, farm, industry, public place (where?)

Means of injury DR. Injured of work?

23. SIGNATURE P.W. Baer

M. D. or other DR. MEDICAL DIRECTOR

Address Frederick, MD Date signed 3-18-50



MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 115

Reg. Dist. No.

131

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGINS RESERVED FOR BINDING



VS. A15

1. PLACE OF DEATH:
 (a) County Frederick Co
 (b) City or town Frederick City
 (c) Street address, hospital, or institution: Frederick City Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
 (a) State Md (b) County Montgomery
 (c) City or town Bearsville Md
 (d) Street No.
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME William Ira Johnson
 3 (b) If veteran, name war C 3 (c) Social Security No. C
 4. Sex Male 5. Color or race Negro 6 (a) Single, married, widowed, or divorced. Single
 6 (b) Name of husband or wife C

6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 3/28/1931
 8. AGE: Years 13 Months 11 Days 25 If less than one day
 hr. _____ min.

9. Birthplace Bearsville Md
 (Town, county, and state)

10. Usual occupation None
 11. Industry or business none
 12. Name Ira Laverne Johnson
 13. Birthplace Bucklodge Md
 14. Maiden Name Ethel Mary Hood
 15. Birthplace Bearsville Md
 16 (a) Informant Ethel Moore
 (b) Address Bearsville Md

17 (a) Burial Buried (b) Date thereof 3/20/1945
 (Burial, exhumation, or removal)
 (c) Cemetery or crematory Poolesville
 Location Poolesville Md

18 (a) Funeral director Clarence H. Davis
 (b) Address Poolesville Md
 19 (a) 24 March 1945 (b) Elizabell G. Heck
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death March 22 - 1945, at 9:15 AM
 21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 - 1945 to 3/22 - 1945; and that I last saw him alive on 3/22 - 1945.

Immediate cause of death auto accident Duration 6 weeks
 Due to Sepicemia Septicemia

Due to _____

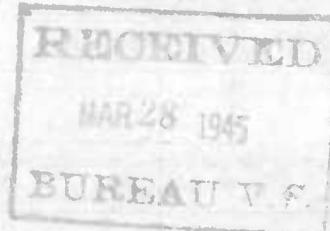
Other conditions _____

(Include pregnancy within 8 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide None
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work?
 (Specify type of place)

(e) Means of injury _____
 23. Signature Brynn D. White M. D. or other _____
 Address Poolesville, Md Date signed 3/22/45



Evidence for change of
year of birth of deceased is shown
on FILM No. G 94 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

02911 38
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Frederick
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME Sallie Kelly

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife William Kelly

7. Birth date of deceased (mo., day, yr.) 1 - 5 - 1876 1878 6. (c) If alive, give age DEAD years

8. AGE: Years 67 Months 2 Days 10 If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Lewis
 13. Birthplace Maryland

MOTHER 14. Maiden name Mattie Pool
 15. Birthplace Maryland

16. Informant Mrs. John P. Kelly cousin

Address New Market, Md.

BURIAL 17. (Burial, cremation, or removal, which) Date thereof 3-18-45
 Cemetery or crematory Pleasant Hill

Location Near Monrovia, Md.

18. Funeral director W.E. Falconer

Address New Market, Md.

19. May 16 1945 Lincoln K. Falconer
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Frederick
 City or town New Market, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Mar 15 1945 and that I last saw her alive on March 13 1945

Immediate cause of death Carcinoma of breast DURATION 2 yrs

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ernest P. Roop, M.D. M. D. or other

Address New Market, Md. Date signed Mar 16 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1

CERTIFICATE OF DEATH

Reg. Dist. No. 02912/81

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town) 40 yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred: Frederick City Hospital
 How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Frederick
 City or town..... Rural - near Frederick Junction
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... Spanish American War

3. (a) FULL NAME

JACOB ALEXANDER KIDWILER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Fannie S. Kidwiler

7. Birth date of deceased (mo., day, yr.) December 27-1874

5.(c) If alive, give age 53 years

8. AGE:	Years	Months	Days	If less than one day
	70	2	4	hrs. min.

9. Birthplace..... Bakerton, West Virginia
 (Town, county, and state)

10. Usual occupation..... Retired Merchant

11. Industry or business

12. Name	James Emanuel Kidwiler
13. Birthplace	Jefferson Co. West Virginia

14. Maiden name	Barbara Ann Hauser
15. Birthplace	Washington Co. Maryland

16. Informant..... Mrs. J.A. Kidwiler
 Address..... nr. Frederick, Junction, Md.

17. Burial..... March 6-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or cemetery..... Mount Olivet Cemetery

Location..... Frederick, Md.
 18. Funeral director..... C.E. Cline and Son

Address..... Frederick, Md.

19. Date rec'd by registrar..... 1945
 (Date rec'd by registrar) Elizabeth G. Heck
 Registrar

3. (b) Social Security Number
 None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 3rd. 1945 at 6:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12th 1944 to March 3d 1945

and that I last saw him alive on March 2d, 1945.

Immediate cause of death..... Metastatic Adenocarcinoma

Due to..... Primary site not determined

Possibly primary in prostate gland

Due to..... Cancer

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Peri-Aortic Tissue - - Date of op. - - / - /

Autopsy results..... Metastatic Adenocarcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Ott. Conley
 C. H. Conley M. D. 00000
 Frederick, Maryland Date signed 3/12/45
 Address.....



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 892

CERTIFICATE OF DEATH

02913 147
Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick

City or town Graceham
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Thirty five years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Josephine Tyler Layman

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Charles Edward Layman

7. Birth date of deceased (mo., day, yr.) Sept 25 1863 6.(c) If alive, give age years

8. AGE: Years 81 Month 5 Days 12 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Ezra Tyler
MOTHER FATHER

13. Birthplace Md

14. Maiden name Elizabeth Moser
MOTHER FATHER

15. Birthplace Md

16. Informant Armabel Luptent

Address Graceham Md.

17. Burial Burial Date thereof March 10 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory United Brethren

Location Thurmont

18. Funeral director Willhicks & Creager

Address Thurmont, Md

19. Date rec'd by registrar Mar. 9 1945 Anna M. Jones
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Graceham
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to Mar. 8 1945 and that I last saw her alive on March 7 1945.

Immediate cause of death Cerebral Hemorrhage DURATION 3 weeks

Due to Chronic Internal Sclerosis 10 yrs

Due to

Other conditions Hemophylgia - Gangrene of legs - foot - 2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Anatomy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Morris A. Birley MD M. D. or other

Address Thurmont Md Date signed 3/8/45

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Regd.*

02914

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County

Fredrick Garfield

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *60 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ann Moriah Lewis

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife

Daniel Lewis

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 18, 1846

8. AGE:

Years

Months

Days

If less than one day

98

8

hrs.

min.

9. Birthplace

Smithsburg

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

John Baker.

12. Name

Smithsburg, Md.

13. Birthplace

Catherine Richard

14. Maiden name

Smithsburg, Md.

15. Birthplace

Mr. Benjamin Lewis

16. Informant

Garfield, Md.

Address

Burial Mar. 20, 1945

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Mt Bethel Cem.

Location

Garfield, Md.

M. L. Creager & Son

18. Funeral director

Thurmont, Md.

Address

Death - 20

1945

(Date rec'd by registrar)

21A Volk.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

no

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 18 1945 at 4 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1943, to Mar 18, 1940

and that I last saw her alive on Mar 18, 1940

Immediate cause of death

General Hemorrhage 4 days

Due to Cerebral Sclerosis 10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

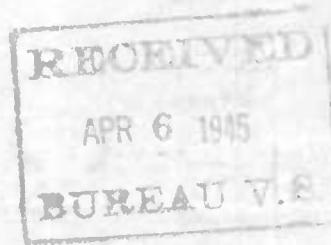
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address I am ill in bed 3/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

02915

Reg. Dist. No. 141

1. PLACE OF DEATH:

County..... Frederick

City or town..... Brunswick (If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?..... 1 week

Hospital, institution, or street address where death occurred: Schaufer's Hospital

How long in hospital or institution?..... 1 week

3. (a) FULL NAME

Etta V. Lewis

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... single

8. (b) Name of husband or wife..... —

7. Birth date of deceased (mo., day, yr.)..... June 12 1858 6. (c) If alive, give age..... years

8. AGE: Years..... 86 Months..... 8 Days..... 28 If less than one day..... hrs..... min.....

9. Birthplace..... Virginia (Town, county, and state)

10. Usual occupation..... —

11. Industry or business..... —

12. Name..... Robert S. Lewis

13. Birthplace..... Va

14. Maiden name..... Beatrice Lynn

15. Birthplace..... Virginia

16. Informant..... R. S. Lewis

Address..... Loretteville Va

17. Burial..... Burial Date thereof..... May 14 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Union

Location..... Loretteville Virginia

18. Funeral director..... P. H. Lee & Son

Address..... Brunswick Md.

19. March 11 1945 Emma Martin
(Date rec'd by registrar) Left Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County..... London

City or town..... Rural Loretteville Va (If outside city or town limits, write RURAL and give nearest town)

Street No..... Near the mountain (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 11 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 4 1945 to March 11 1945 and that I last saw her alive on March 11 1945

Immediate cause of death.....

Fracture of (Right) neck of femur

DURATION

1 Wk.

Due to..... Fall

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... accident Date of 3/4/45

Where did injury occur?..... Loretteville, Loudon, Va (City or town) (County) (State)

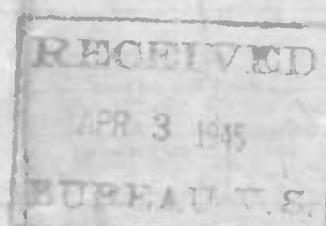
Injured at home, farm, industry, public place (where?)..... Home

Means of injury..... Falling Room Injured at work? no

23. SIGNATURE..... WB Crumpler

M. D. or other

Address..... Loretteville, Va Date signed 4/11/45



STATE OF MARYLAND—CERTIFICATE OF DEATH

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County *Frederick*
Village or City *Dr. Hyattstown*

Length of residence in city or town where death occurred

yrs.

mos.

ND.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

73d

Registration Dist. No.

136

St.

Ward

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St. Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male *White*

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)
Widowed

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Jane E. Wagner*

6. DATE OF BIRTH (month, day, and year)

Aug 20 - 1864

7. AGE

Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
80	10	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.
Farmer
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

*9-44*11. Total time (years) spent in this occupation *Life*

12. BIRTHPLACE (city or town)

(State or country)

*Dr. Hyattstown**Frederick Co., Md.*

MOTHER FATHER

13. NAME *Edmund W. McElfresh*

14. BIRTHPLACE (city or town)

(State or country)

*Maryland*15. MAIDEN NAME *Mary H. McElfresh*

16. BIRTHPLACE (city or town)

(State or country)

Maryland

17. INFIRMAT

(Address)

*Bureau of Fisheries**Hyattstown, Md.*

18. BURIAL, CREMATION, OR REMOVAL

Place

Hyattstown

Date

4-2 1945

19. UNDERTAKER

(Address)

*M. L. Burdette**Hyattstown, Md.*

20. FILED

4/2

*1945**G. O. Hendrickson*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

March 30
(Month) (Day)*1945*
(Year)

22. I HEREBY CERTIFY That I attended deceased from

Feb 20, 1945, to *March 30, 1945*I last saw him alive on *March 29, 1945*; death is said to have occurred on the date stated above, at *3 P.M.*

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

*1943**Myocarditis**1935**Arterio sclerosis*

Other Contributory Causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) *Ernest P. Roop*
M. D.
(Address) *New Market, Md.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset
Chronic interstitial nephritis	1915
Cerebral hemorrhage	1921

Other contributory causes of importance:

Gallstones	Date of onset
	July 5, 1927
	May 1, 1928

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset
Run over by street car	1 week ago
Peritonitis	1 week ago

Other contributory causes of importance:

Gastroenteritis	Date of onset
	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

02917

CERTIFICATE OF DEATH

Reg. Dist. No. 145

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *(Frederick)*
 County: *Marysville* RFD
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*
 How long in above place of death? *24 years*
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants, give residence of mother)
 State: *Maryland* County: *(Frederick)*
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*
 Street No.:
 (If rural, give LOCATION)
 2.(a) If veteran, name war: *W.W.*

3. (a) FULL NAME *(Nellie Lucinda Michael)*
 4. Sex: *Female* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*
 6. (b) Name of husband or wife: *Nancy Michael*
 7. Birth date of deceased (mo., day, yr.): *Sept. 19, 1871* 8. (c) If alive, give age: *66* years
 8. AGE: Years: *73* Months: *6* Days: *11* If less than one day: _____ hrs. _____ min.
 9. Birthplace: *Marysville, Frederick County, Md.* (Town, county, and state)
 10. Usual occupation: *Housewife*
 11. Industry or business: *John Miser*
 12. Name: *John Miser*
 13. Birthplace: *Marysville, Md.*
 14. Maiden name: *Lucinda Hershey*
 15. Birthplace: *Middletown, Md.*
 16. Informant: *Nancy Michael*
 Address: *Burial, Marysville*
 17. (Burial, cremation, or removal, Which?) *Burial* Date thereof: *Aug. 2 1945* (month) (day) (year)
 Cemetery or crematory: *United Brethren*
 Location: *Marysville, Md.*
 18. Funeral director: *Flagstaff Company*
 Address: *Middletown, Md.*
 19. April 2 1945 Edgar Bittle
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number: *None*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *March 30* 1945 at 3 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 30* 1945 to *March 30* 1945 and that I last saw her alive on *March 30* 1945

Immediate cause of death: *Coronary Thrombosis.*
 Due to: _____
 Due to: _____
 Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: *G. W. Lillian M. W.*
 M. D. or other: _____
 Address: *Bowensboro, Md.* Date signed: *3/31/45*

VS A15

APR 30 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct age
is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83D

02918

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:
Wilson Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wilson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME
AMANDA ALICE MILLER

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>W</u>
-----------------	---------------------------	--

6.(b) Name of husband or wife John W. Miller

7. Birth date of deceased (mo., day, yr.) August 6, 1865

8. AGE: Years <u>79</u>	Months <u>6</u>	Days <u>25</u>	If less than one day hrs. min.
-------------------------	-----------------	----------------	--

9. Birthplace New Midway-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER Andrew J. Eyler
 12. Name Frederick County Maryland

MOTHER Sarah Albaugh
 13. Birthplace Frederick County Maryland

14. Maiden name Roy E. Miller

15. Birthplace Frederick, Maryland R. F. D. #3

16. Informant Burial Date thereof 3/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Olivet Cemetery
 Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son
 Address Frederick, Maryland

19. Elizabeth G. Heck Registrar
 (Date rec'd by registrar) 19-45

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st, 1945 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 25, 1945 to March 1st, 1945,
 and that I last saw her alive on Feb 28, 1945.

Immediate cause of death	DURATION
<u>Central Hemorrhage</u>	<u>4 days</u>
<u>Stomach Hemorrhage</u>	<u>103 days</u>
<u>Central Hemorrhage</u>	<u>19-27-1</u>

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

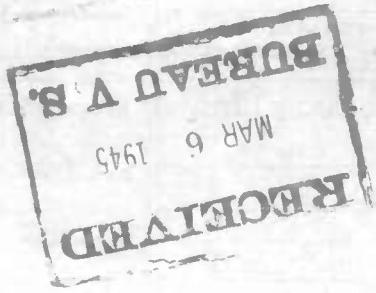
Injured at work?

23. SIGNATURE F. H. Heck

M. D.

M. D. or other

Address Frederick, Maryland Date signed 3-1-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

02919

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH: Frederick
 County.....
 City or town..... State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since March 20, 1945
 Hospital, Institution, or street address where death occurred:
 Maryland Tuberculosis Sanatorium
 Since March 20, 1945
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 616 N. Augusta Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME
 William D. Mollman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 23, 1890
 B.(c) If alive, give age years

8. AGE:	Years	Months	Days	If less than one day
	55	1	25	hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... Lithographer

11. Industry or business
 FATHER 12. Name..... Unknown

MOTHER 13. Birthplace " "

14. Maiden name..... Unknown
 15. Birthplace " "16. Informant..... Information taken from application blank for admission.
 Address.....17. Burial..... Date thereof..... 3/22/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery..... Loudon Park

Location..... Baltimore, Maryland

18. Funeral director..... M. L. Creager & Son
 Address..... Thurmont, Maryland19. Date rec'd by registrar..... 3/10/45
 (Date rec'd by registrar) 19.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 20 1945 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 March 20 1945 to Mar. 20 1945
 and that I last saw him alive on March 20 1945.Immediate cause of death..... Pulmonary Tuberculosis
 DURATION 1 Mo.

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

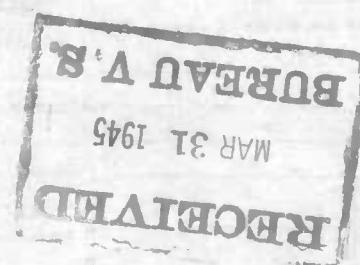
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. B. Lynn M. D. XXXX

Address..... State Sanatorium, Md. Date signed 3/22/45



PLEASE WRITE PLAINLY, WITH UNFADING INK,
especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02920

Reg. Dist. No. 131

1. PLACE OF DEATH

County BaltimoreCity or town Baltimore City Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Baltimore City Hospital

How long in hospital or institution?

3. (a) FULL NAME

Elsie Mulline4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedB. (d) Name of husband or wife William J. S. Mulline7. Birth date of deceased (mo., day, yr.) May 1, 1886 8. (c) If alive, give age 77 years8. AGE: Years 58 Months 10 Days 24 If less than one day
hrs. min.9. Birthplace Montgomery County
(Town, county, and state)10. Usual occupation House Wife11. Industry or business None12. Name Richard Burditt13. Birthplace Maryland14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. William J. S. MullineAddress Morovia, MD17. Burial Burial Date thereof March 22, 1945
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory BethesdaLocation Maryland18. Funeral director P. W. BarberAddress Logstownville, MD19. Date of death March 24, 1945 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town BethesdaPost Office R. D. B.

Street No.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1945 at 9 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw her ~~alive~~ dead on March 24, 1945Immediate cause of death InfectionDue to Burns of thighs, abdomen & left hand.Degree 2nd & 3rd degree

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

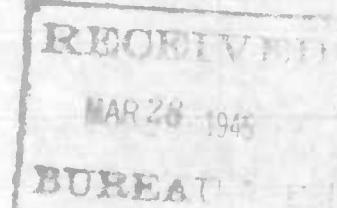
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan 13, 1945Where did injury occur? Morovia Funeral Home (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Neighbors HomeMeans of Injury Boiled oil oil in stone when exploded. Injured at work? No23. SIGNATURE P. W. BarrM. D. or other Federal Date signed 3-24-45Address Federal, MD

RECEIVED TO TENNESSEE STATE CHARTER

UTAH STATE CORPORATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-^b

02921

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County..... Frederick

City or town..... State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? Since June 26, 1944

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since June 26, 1944

3. (a) FULL NAME

Clinton Oliver

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Sept. 18, 19028. AGE: Years Months Days If less than one day
42 5 11 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business Produce

12. Name ? Oliver

13. Birthplace Baltimore, Md.

14. Maiden name Annie ?

15. Birthplace Baltimore, Md.

16. Informant Deceased

Address

17. Burial Date thereof 3/5/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery New Cathedral

Location Baltimore, Md.

18. Funeral director M. L. Creager & Son

Address Thurmont, Maryland

19. 3/1/45 19.....
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 737 W. Fayette
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1944 to March 1 1945
end that I last saw him alive on March 1 1945

Immediate cause of death

Pulmonary Tuberculosis

DURATION

14 Mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

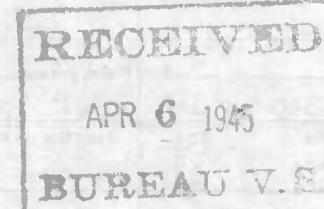
23. SIGNATURE.....

M. D. DEXTER

Address State Sanatorium, Md. Date signed 3/2/45

RECEIVED TO TRANSMITTER STATE CHARTER

RECEIVED TO TRANSMITTER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B-2)*

62922

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County..... Frederick

City or town..... State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Since June 16, 1937

How long in above place of death?

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since June 16, 1937

3. (a) FULL NAME

Margaret C. O'Neill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

8. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 12, 1900

8. AGE:

Years
44Months
8Days
8If less than one day
..... hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Wrapper

11. Industry or business

MOTHER FATHER

12. Name..... Patrick O'Neill

13. Birthplace..... Ireland

14. Maiden name..... Anna Bray

15. Birthplace..... Maryland

16. Informant.....

Address

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 3/22/45

(month) (day) (year)

Cemetery or place..... New Cathedral

Location..... Baltimore, Maryland

18. Funeral director..... William Cook

Address..... St. Paul St., Balto., Md.

19. (Date rec'd by registrar) 3/20/45

19. (Date signed) 3/20/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 2014 N. Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 20 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1937 to March 20 1945 and that I last saw her alive on March 20 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

32 Yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

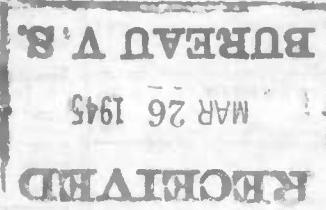
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... *R. L.*M. D. *XXXXXX*

Address..... State Sanatorium, Md. Date signed 3/20/45



RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

02923

Reg. Dist. No.

131

1. PLACE OF DEATH:

County..... Frederick

City or town..... Frederick

(If outside city or town limits, write RURAL and give nearest town)

Lifetime

How long in above place of death?

Hospital, institution, or street address where death occurred:

38 E. 2nd. St.

How long in hospital or institution?

3. (a) FULL NAME

CHARLOTTE ELIZABETH PYLES

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or..... Dr. Joseph T. Pyles

7. Birth date of deceased (mo., day, yr.) June 10-1883

8. AGE: Years	Months	Days	It less than one day
61	9	9	hrs. min.

9. Birthplace..... Frederick County Maryland

(Town, county, and state)

10. Usual occupation..... Retired Housewife

11. Industry or business

12. Name..... Joseph E. Powers

13. Birthplace..... Frederick, Md.

14. Maiden name..... Emma Kate Lorentz

15. Birthplace..... Frederick, Md.

16. Informant..... Mrs. Foster K. Burkett

Address..... Altoona, Penna.

17. Burial..... Date thereof..... 3/22/45

(Burial, cremation, entombment, etc.) (month) (day) (year)

Cemetery or..... Mount Olivet Cemetery

Location..... Frederick, Md.

18. Funeral director..... C.E. Cline and Son

Address..... Frederick, Md.

19. 20 March 1945 (Date rec'd by registrar) Elizabeth G. Heck. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No..... 38 E. 2nd. St. (If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 19 1945 at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 1944 to March 19 1945

and that I last saw her alive on March 12 1945

Immediate cause of death..... Cerebral hemorrhage

DURATION

3 hrs.

Due to..... My pulmonary & arteriosclerosis

5 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... R.W. Barr M. D. or other

Address..... Frederick, Md. Date signed 3.1.20.45

RECEIVED
MAR 22 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

02924-141

Reg. Dist. No.

1. PLACE OF DEATH:

County *Frederick*
City or town *Brunswick*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Schauffler Hospital
23 days

How long in hospital or institution?

3. (a) FULL NAME

James Harvey Reed.

4. Sex

5. Color or race

6. (a) Single, married-widowed, or divorced

Male *white* *widowed*

6. (b) Name of husband or wife

Bessie Faye

7. Birth date of deceased (mo., day, yr.)

Oct. 6 1884

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

It less than one day

60

5

2

.hrs. min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Painter
Painting

11. Industry or business

James R. Reed

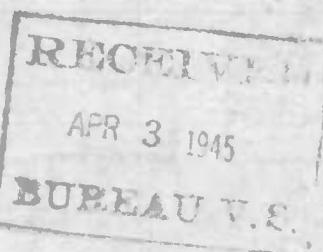
FATHER

MOTHER

MOTHER

FATHER

MOTHER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

02925

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH:

County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

5 days

How long in above place of death?

Hospital, Institution, or street address where death occurred: Frederick City Hospital

How long in hospital or institution? 5 days

3. (a) FULL NAME

Robert Franklin Reed.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

8. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

July 21, 1915

8. AGE: Years	Months	Days	If less than one day
29	7,	13	hrs. min.

9. Birthplace Thurmont, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business Laborer

12. Name Charles Richard Reed

13. Birthplace Thurmont, Md.

14. Maiden name Rose L. Freshman

15. Birthplace Thurmont, Md.

16. Informant Charles Richard Reed

Address Thurmont, Md.

17. Burial March 7, 1945

(Burial, cremation, or removal; Which? Date thereof (month) (day) (year))

Cemetery or sea United Brethren Cem.

Location Thurmont, Md.

18. Funeral director M. L. Creager & Son

Address Thurmont, Md.

19. (Date rec'd by registrar) 19.45

(Dated rec'd by registrar) 19.45

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

Other town Thurmont - rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 4, 1945, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1945, to March 4, 1945, and that I last saw him alive on March 4, 1945.

Immediate cause of death 1035 P.M. DURATION

Acute myocarditis

Due to:

Due to:

Other conditions Plasmic Poisoning

(Include pregnancy within 8 months of death)

Major findings or operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

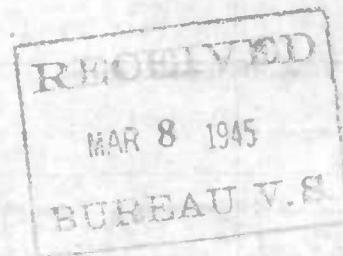
Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Frederick, Md. Date signed: March 8, 1945

MESSAGE TO THE UNITED STATES GOVERNMENT

RECEIVED BY SECRETARY OF STATE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45B

02926

CERTIFICATE OF DEATH

Reg. Dist. No. 139

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Frederick

City or town..... State Sanatorium, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12/18/44

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since 12/18/44

3. (a) FULL NAME

Edward Reekers

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Separated

6.(b) Name of ~~wife~~ wife..... Helen Reekers

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1872

8.(c) If alive, give age Unknown

8. AGE: Years Months Days If less than one day
72 5 8 hrs. min.9. Birthplace..... Covington, Ky.
(Town, county, and state)

10. Usual occupation..... Painter

11. Industry or business

FATHER 12. Name..... Harmon Reekers

MOTHER 13. Birthplace..... Germany

14. Maiden name..... Susie Brink

15. Birthplace..... Germany

18. Informant..... Deceased

Address

17. Unknown Burial Date thereof: 3/21/45 Unknown
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Unknown 3/24/45
Blue Ridge Cemetery

Location..... Unknown Thurmont, Md.

18. Funeral director..... M. L. Creager & Son

Address

Thurmont, Md.

19. (Date rec'd by registrar) 3/21/45

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Belair & Joppa Rds.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 1944, to March 20 1945,

and that I last saw him alive on March 20 1945.

Immediate cause of death

Carcinoma of Tongue

DURATION

6 Mos.

Due to.....

Due to.....

Other conditions Pulmonary Tuberculosis

5 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

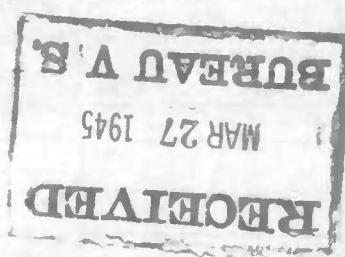
Means of injury

Injured at work?

23. SIGNATURE J. B. D. M. D. O. M. A. X. X. X.

Address..... State Sanatorium, Md. Date signed..... 3/20/45

VS-A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

02927

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

Eleanor Virginia Renner4. Sex F5. Color or race W

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 19398. AGE: Years 5Months 2Days 17

If less than one day

hrs. min.

9. Birthplace Frederick, Frederick Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name John Renner

MOTHER

13. Birthplace Thurmont, Md

FATHER

14. Maiden name Edna Carpenter

MOTHER

15. Birthplace McKaign, Md

FATHER

16. Informant John J. Renner

Address

Frederick Md

Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/3/45
(month) (day) (year)Cemetery or crematory Glade Cemetery

Location

Wachettsville, Md18. Funeral director Henry E. Carter Co.

Address

Frederick Md19. 3 April

1945

(Date rec'd by registrar)

Elizabeth H. Heek.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 53 S. N. Market St

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31

18 45 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 1945

and that I last saw her alive on March 31 1945Immediate cause of death TuberculosisPneumonia is fact

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

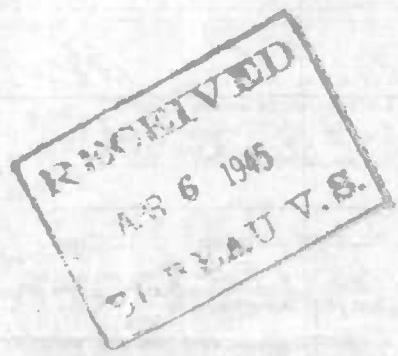
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-32-45Where did injury occur? Frederick, Frederick Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury Ran nail in foot Injured at work? No23. SIGNATURE R.W. Barr Deputy Med. Sec.

M. D. or other

Address Frederick, Md Date signed 3-31-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13B

02928

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County.....

Frederick

City or town.....

Reister

Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6 Maryland Hospital

How long in hospital or institution?

2 months

3. (a) FULL NAME

Nannah Mae Remsing

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Amos H. Remsing

7. Birth date of deceased (mo., day, yr.)

Sept. 1 - 1876

6.(c) If alive, give age

years

8. AGE:

Years
68Months
6Days
21

If less than one day

hrs.

min.

9. Birthplace.....

Middletown Frederick County Md.

(Town, County, and state)

10. Usual occupation.....

Waverly

11. Industry or business

Lewis & Sinsel

FATHER

12. Name.....

Lewis Sinsel

MOTHER

13. Birthplace.....

Burkittsville Md.

14. Maiden name.....

Jane Wootright

15. Birthplace.....

Burkittsville Md.

16. Informant.....

Robert Remsing

Address.....

Thurmont Md.

17. Burial.....

Burial

(Burial, cremation, or removal, which?)

Date thereof..... Mar. 24 1945

(month) (day) (year)

Cemetery or.....

Bucktun Cemetery

Location.....

Middletown Md.

18. Funeral director.....

J. Leibnitz Co

Address.....

Middletown Md.

19. 23 March

1945

(Date rec'd by registrar)

Elizabeth G. Heck.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For all born infants give residence of mother)

State.....

Maryland

County.....

Frederick

City or town.....

Middletown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 24 1945 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1

1945

to March 24 1945

and that I last saw her alive on March 24 1945

Immediate cause of death.....

Amenia

DURATION

10 days

Due to.....

Chronic nephritis 2 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

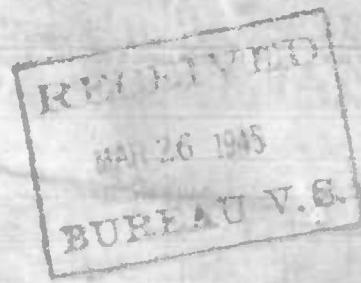
Injured at work?

23. SIGNATURE

John M. Smith

M. D. or other

Address..... Frederick Md. Date signed..... 3-28-45



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

CERTIFICATE OF DEATH

62929
Reg. Dist. No. 139

1. PLACE OF DEATH:
County..... Frederick
City or town..... State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Since Oct. 14, 1943
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution?..... Since Oct. 14, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME
William A. Schmidt

3. (b) Social Security Number
218-01-3281

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

B. (b) Name of husband & wife..... Alma Schmidt

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... August 9, 1902

8. AGE: Years	Months	Days	11 less than one day
42	6	26	hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Drill Press Operator

11. Industry or business

FATHER	12. Name..... William H. Schmidt
MOTHER	13. Birthplace..... Pennsylvania

FATHER	14. Maiden name..... Mathilda M. Kroger
MOTHER	15. Birthplace..... Washington, D. C.

16. Informant..... Deceased

Address

17. Burial..... Date thereof..... 3/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery..... Cedar Hill

Location..... Baltimore Co.

18. Funeral director..... M. L. Creager & Son

Address..... Thurmont, Maryland

19. (Date recd by registrar)..... 18..... Registrars

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 7 1945 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 14, 1943, to March 7, 1945,

and that I last saw him alive on March 7, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION..... 20. Mo.s.

22. Cause..... Tuberculous Enteritis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... D. B. Lynn

M. D. MMXX Date signed 3/8/45



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

02930

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:

County.....

City or town.....

Frederick
Myersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Myersville, Fred. Co. Md.
(Town, county, and state)

10. Usual occupation.....

Schoolm

11. Industry or business

Myersville Public School

MOTHER FATHER

12. Name.....

Atlee G. Shepley

13. Birthplace

Myersville, Md.

14. Maiden name.....

Nora Toms

15. Birthplace

W. Myersville, Md.

16. Informant.....

Atlee G. Shepley

Address

Myersville, Md.

17. Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

United Brethren

Location.....

Myersville

18. Funeral director.....

J. Thomas Batty & Son

Address

Myersville, Md.

19. April 2, 1945

Edgar Batty

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Mar 31 1945 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1945, to Mar 31, 1945,
and that I last saw him alive on Mar 30, 1945.

Immediate cause of death.....

Lymphatic Leukemia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

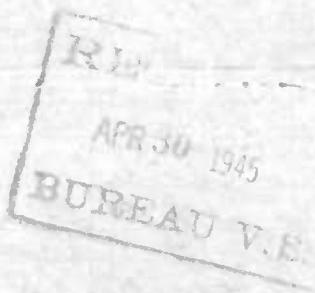
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH
residence of deceased is shown on 2411 N. Charles St., Baltimore 92931

CERTIFICATE OF DEATH

02931

138

Reg. Dist. No. 138

FILM NO G 94 MAY 11 1945

I. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Zather Stewart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

8. AGE Years Months Days If less than one day about 68 hrs. min.

9. Birthplace.....

(Town, county, and state)

Frederick Co.

10. Usual occupation.....

Tabor

11. Industry or business

West Stewart

12. Name.....

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?) Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Mar. 19 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Frederick

City or town.....

Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 19 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. l. 17 alive on March 19 1945

Immediate cause of death.....

Coronary occlusion

DURATION

Due to..... chronic myocarditis

duration

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

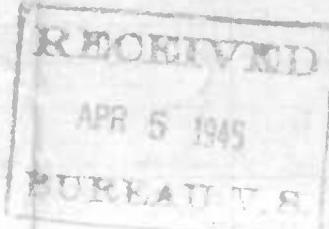
Injured at work?

23. SIGNATURE.....

P.W. Boe Deputy Med Ex

M. D. or other

Address..... Frederick, Md Date signed 3.19.45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

02932

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
Frederick
County.....
City or Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

3. (a) FULL NAME

ETHAN PHILIP SUMMERS, JR.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 28, 1945

8. AGE: Years	Months	Days	If less than one day
1	18	hrs.	min.

9. Birthplace..... Frederick-Frederick-Maryland
(Town, county, and state)

10. Usual occupation..... Infant

11. Industry or business.....

12. Name..... Ethan P. Summers, Sr.

13. Birthplace..... Frederick County Maryland

14. Maiden name..... Marie L. Flock

15. Birthplace..... Frederick County Maryland

16. Informant..... Mrs. E. P. Summers, Sr.

Address..... Mount Airy, Maryland - Rural

17. Burial..... Date thereof..... 3/17/45
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or Mount Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son

Address..... Frederick, Maryland

19. Date rec'd by registrar..... 17 March 1945..... Elizabeth H. Tech..... Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Mount Airy - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Near New Market
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 16, 1945, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 26, 1945, to March 16, 1945,

and that I last saw him alive on March 15, 1945.

Immediate cause of death..... Collapse of lung

Due to..... Following operation
(Ramstedt pyloroplasty)

Due to..... Congenital pyloric

stenosis (Hypertrophic)

Other conditions..... Mal-nutrition

(Include pregnancy within 8 months of death)

Major findings of operations..... Congenital pyloric

stenosis..... Date of op. Feb. 27th.

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

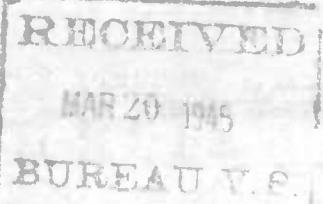
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Frank W. Mortenson M. D.

M. D. or other

Address..... Frederick, Maryland Date signed 3-16-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1610

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County..... Frederick
City..... Hansonville - rural nr. Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Harold Hedges

Sunday

3. (b) Social Security Number
none

4. Sex 5. Color or race 6.(a) Single, married, widowed or divorced

Male White Married

6.(b) Name of husband or wife..... Mary Rebecca Stull

7. Birth date of deceased (mo., day, yr.)..... January 11, 1903

6.(c) If alive, give age..... 35 years

8. AGE: Years Months Days If less than one day
42 2 8 .hrs. min.9. Birthplace..... Hansonville, Frederick Co., Md
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

FATHER	12. Name..... Clinton R. Sunday
	13. Birthplace..... Hansonville, Md.

MOTHER	14. Maiden name..... Elsie I. Ramsburg
	15. Birthplace..... Charlesville, Md.

16. Informant..... Mrs. Harold H. Sunday.

Address..... Frederick R.F.D. Md.

17. Burial Date thereof. March 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ground..... Utica Cemetery

Location..... Utica, Md.

18. Funeral director..... M. L. Creager & Son

Address..... Thurmont, Md.

19. 22 March 1945
(Date rec'd by registrar)Elizabeth G. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Frederick

City or town..... Hansonville - rural.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war..... no

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 19 1945 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. l. o. dead March 19 1945
alive on 19 10 19 19 45

Immediate cause of death.....

Gun shot wound of chest
Due to..... three, hemorrhage

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

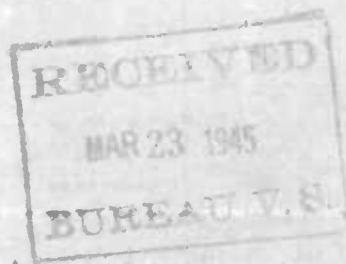
Accident, suicide, or homicide..... Suicide Date of 3.19.45
Where did injury occur? near Hansonville, Frederick, Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... farm

Means of injury 12 ga shotgun Injured at work? yes

23. SIGNATURE..... P. W. Baer
M. D. or other

Address..... Frederick, Md. Date signed 3/20/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

02934

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Hour
Hospital, institution, or street address where death occurred:
185 West All Saint Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 185 West All Saint Street
(If rural, give LOCATION)
None

3. (a) FULL NAME
ALICE LUCILLE THOMPSON

4. Sex F	5. Color or race C	6. (a) Single, married, widowed, or divorced S
----------	--------------------	--

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 10, 1945
8. (c) If alive, give age years

8. AGE: Years	Months	Days	It less than one day
			1 hrs. min.

9. Birthplace Frederick-Frederick-Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER
12. Name William A. Thompson
13. Birthplace Frederick County Maryland

MOTHER
14. Maiden name Blanche Fredericks
15. Birthplace Montgomery County Maryland

16. Informant Mrs. Blanche F. Thompson
Address 185 W. All Saint St., Fred'k, Md.

17. Burial Date thereof 3/11/45
(Burial, cremation, or removal, which) (month) (day) (year)
Cemetery or place Ebenezer Cemetery

Location Ijamsville, Maryland-Rural
18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. (1) March 1945-
(Date rec'd by registrar) Elizabeth G. Heck
Registrar

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th, 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3/10 1945 to 1945
and that I last saw her alive on 3/10/45 1945

Immediate cause of death Prema turty DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

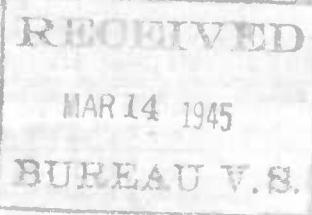
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE H. G. Bourne Jr. M. D.
M. D. or other

Address Frederick, Maryland Date signed 3-11-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

02935

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

E. J. Thompson

4. Sex

Male White Married

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife.....

Ethel Thompson

7. Birth date of deceased (mo., day, yr.)

Dec. 1, 1896

B. (c) If alive, give age..... years

8. AGE:

Years Months Days It less than one day
58 11 23 hrs. min.

9. Birthplace.....

Nameoki Illinois

(Town, county, and state)

10. Usual occupation.....

Farm Manager

11. Industry or business

John Thompson

Indiana

FATHER

12. Name.....

John Thompson

Indiana

13. Birthplace

Farnham Cabin

Illinois

MOTHER

14. Maiden name.....

Farnham Cabin

15. Birthplace

Mrs. Ethel Thompson

Knoxville, Md.

16. Informant

Burial

Date thereof Mar. 27 1945

(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory Relojed (Relojed) Cemetery

Location

Middleton, Md.

18. Funeral director

Radhill Company

Address

Middleton, Md.

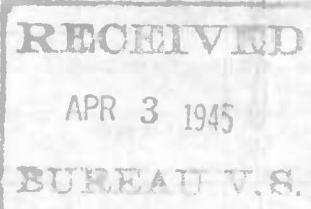
19. M. D. or other

Eduard Martin

(Date rec'd by registrar)

Registrar

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

02936

Reg. Dist. No. 131

1. PLACE OF DEATH:
County: Frederick

Off or town: Rural Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo

Hospital institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 8 mo

3. (a) FULL NAME: William Toms (of a)

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Clara Brown

7. Birth date of deceased (mo., day, yr.): June 13 - 1863 8. (c) If alive, give age: years

8. AGE: Years: 81 Months: 9 Days: 18 If less than one day: hrs. min.

9. Birthplace: Foxville Frederick MD (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Abraham Toms

12. Name: Abraham Toms

13. Birthplace: Foxville Frederick MD

14. Maiden name: Susan Bowmar

15. Birthplace: Foxville Frederick MD

16. Informant: Mrs. W.A. Smith

Address: Layton MD

17. Burial: Burial Date thereof: April 4-1948
(Burial, cremation, or removal, whichever)

Cemetery or crematory: Bethel Cemetery

Location: Near Garfield Frederick MD

18. Funeral director: J. L. Creager Son

Address: Hurlock MD

19. Registrar: Elizabeth G. Heek

Date received by registrar: 2 April 1945

Date signed: Elizabeth G. Heek

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD County: FrederickOff or town: Foxville (If outside city or town limits, write RURAL and give nearest town)Street No.: (If rural, give LOCATION)2. (a) If veteran, name war: WW3. (b) Social Security Number: 111-11-1111

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1945 at 10:30 AM21. I CERTIFY that death occurred on the date above stated: That I attended deceased from July 26 1944 to March 31 1945and that I last saw him alive on March 31 1945Immediate cause of death: SenilityDue to: Cardio Vasculon Renal DiseaseDue to: Cardiac DecompositionOther conditions:

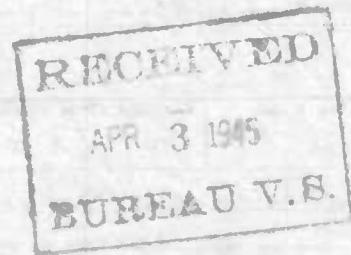
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.: Autopsy results:

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE: H. Lawrence Faloney MDM.D. or other Address: Frederick MD Date signed: 3-31-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

02937

CERTIFICATE OF DEATH

Reg. Dist. No. 131

MARGIN RESERVED FOR BINDING



VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		County <u>Fredrick</u>	
City or town <u>Fredrick</u>		(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? <u>7 days</u>		Hospital, Institution, or street address where death occurred: <u>Baltimore Hospital</u>	
How long in hospital or institution? <u>7 days</u>			
3. (a) FULL NAME <u>Katie M. Troxell</u>			
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife.....		6. (c) If alive, give age..... years	
7. Birth date of deceased (mo., day, yr.) <u>May 7, 1865</u>		8. AGE: Years <u>79</u> Months <u>10</u> Days <u>15</u> If less than one day hrs. min.	
9. Birthplace <u>Thurmont, Fredrick Co. Md.</u> (Town, county, and state)		10. Usual occupation <u>Housewife</u>	
11. Industry or business <u>Own home</u>		12. Name <u>Alfred A. Troxell</u>	
13. Birthplace <u>Thurmont - Maryland</u>		14. Maiden name <u>Miranda Weller</u>	
15. Birthplace <u>Thurmont - Maryland</u>		16. Informant <u>Mrs. J. P. Style</u>	
Address <u>Thurmont, Md.</u>		17. Burial <u>Burial</u> Date thereof <u>Mar. 24, 1945</u> (Burial, cremation, or removal, where?) (month) (day) (year)	
Cemetery or crematory <u>United Brothers</u>		18. Funeral director <u>M. L. Preacher & Son</u>	
Location <u>Thurmont, Md.</u>		Address <u>Thurmont, Md.</u>	
19. Funeral director <u>M. L. Preacher & Son</u>		Address <u>Thurmont, Md.</u>	
19. Date rec'd by registrar <u>23 March 1945</u>		19. Registrar <u>Elizabeth J. Heek</u>	

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Fredrick
City or town Fredrick
Street No. East Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war W.W.II3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945 at 3:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1945 to Mar. 22, 1945 and that I last saw her alive on March 22, 1945. Immediate cause of death Paralysis.DURATION 10 daysDue to Cerebral HemorrhageDue to Arterio Atherosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. M. Smith M.D.

M. D. or other

Address Fredrick, Md. Date signed 3-22-45

RECEIVED
MAR 28 1945
BUREAU V.S.

~~M~~ PLEASE WRITE PLAINLY, WITH UNFADING INK,
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

CERTIFICATE OF DEATH

02938

Reg. Dist. No. 144

1. PLACE OF DEATH:

County. Frederick

City or town. Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Lifetime.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sadie Margaret Weddle.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife. Charles W. Weddle

7. Birth date of deceased (mo., day, yr.) July 28, 1870

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
74 8 I hrs. min.9. Birthplace. Thurmont, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation. Housework

11. Industry or business. Home

12. Name. Elijah Willhide

13. Birthplace. Thurmont, Md.

14. Maiden name. Sadie Margaret Willhide

15. Birthplace. Thurmont - Md.
Libert S. Weddle.

16. Informant.

Address. Thurmont, Md.

17. Burial. Date thereof. April 1, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory. Blue Ridge Cem

Location. Thurmont, Md.

18. Funeral director. M. L. Creager & Son

Address. Thurmont, Md.

19. Mar. 31, 1945. Anna M. Jones
(Date rec'd by registrar)

15

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland County. Frederick

City or town. Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. Church Street

(If rural, give LOCATION)

No

2. (a) If veteran, name war.

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH. March 30, 1945, at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25th 1945 to Mar. 30th 1945 and that I last saw her alive on Mar. 29th 1945.

Immediate cause of death.

Acute Myocarditis

DURATION

5 days

Due to. Acute Rheumatism

7 weeks

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

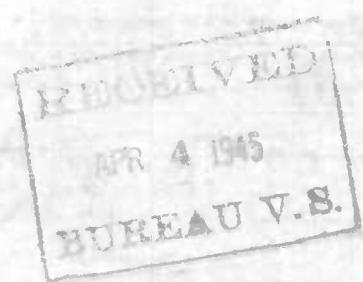
Means of injury

Injured at work?

23. SIGNATURE

Morris A. Berry, M.D. M. D. or other

Address. Thurmont, Md. Date signed 3/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK, Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 912

CERTIFICATE OF DEATH

02939

Reg. Dist. No. 141

1. PLACE OF DEATH: Baltimore Frederick
 County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days
 Hospital, institution, or street address where death occurred: Schrafft's Hospital
 How long in hospital or institution? 13 days

3. (a) FULL NAME

William Arthur Wells

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) February - 28 - 1886

8. AGE: Years 59 Months 0 Days 22 If less than one day hrs. min.

9. Birthplace Birmingham Alabama
 (Town, county, and state)

10. Usual occupation Retired Mechanical Engineer

11. Industry or business

MOTHER FATHER
 12. Name H. W. Wells
 13. Birthplace Ocoba Mills Penna.

MOTHER
 14. Maiden name Fda Estep
 15. Birthplace Ocoba Mills Penna.

16. Informant Ralph Kaelbel
 Address Gapsland Md.

17. Burial: Burial Date thereof March 23, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of the Brethren Cemetery

Location Baltimore Md.

18. Funeral director Wm. J. Best & Sons
 Address Boonsboro Md.

19. March 21 1945 Emmet Martin
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Washington
 City or town Gapsland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Gapsland Md.
 (If rural, give LOCATION)

2.(a) If veteran, name war - None -

3. (b) Social Security Number

219-20-3523

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 4 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1945 to March 20 1945, and that I last saw him alive on March 20 1945.

Immediate cause of death Coronary Thrombosis

Due to:

Due to:

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

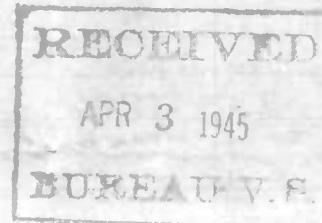
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE William Schrafft M.D.
 M.D. or other

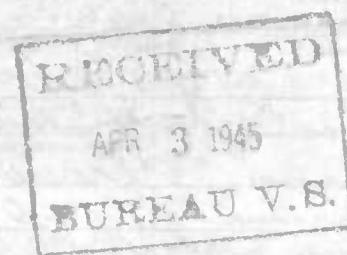
Address Baltimore Date signed March 26 1945

RECEIVED BY THE FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
CERTIFIED



BY MAIL TO THE UNITED STATES GOVERNMENT

MAIL TO THE UNITED STATES GOVERNMENT



PLEASE WRITE PLAINLY, WITH UNFADING INK,
Supply every item of information carefully. The correct age
is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02941

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County

Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

711 Maryland Ave

How long in hospital or institution?

3. (a) FULL NAME

Katherine E Wilson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband

Wm D. Wilson

7. Birth date of deceased (mo., day, yr.)

January 1-1866

6. (c) If alive, give age

years

8. AGE:

79

2

23

If less than one day

hrs.

min.

9. Birthplace

Harford Co Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

John N. Ely

Harford, Co., Md.

MOTHER

Hannah

Frank Ely

Forest Hill, Md

15. Birthplace

16. Informant

Mrs Frank Hamby

Address

4202 Belair Ave Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Where?)

Mt Zion

Date thereof

Mar 23 45

(month) (day) (year)

Cemetery or crematory

near Belair, Md

Location

Dean Foster

18. Funeral director

Address

Bel Air, Md

19. Date rec'd by registrar

1945

Elizabeth S. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Mar 23, 1945, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her dead March 23, 1945.

Immediate cause of death

coronary occlusion

DURATION

immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

DR. R. W. BAER

DEPUTY MED. L.

BAER

Injured at work?

23. SIGNATURE

R. W. Baer

M. D. No. 32344

Address

RECEIVED
MAR 28 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

02942

CERTIFICATE OF DEATH

Reg. Distr. No. 131

1. PLACE OF DEATH:

County

City or town

Fred. City Hospital
Frederick County
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Fred. City Hospital
 (If outside city or town limits, write RURAL and give nearest town)

How long in hospital or institution?

3. (a) FULL NAME

Baby girl Magly

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 6 - 1945

8. AGE:

Years
0Months
0Days
1It less than one day
hrs. min.

9. Birthplace

Fred. City Hospital
 (Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name *Donald Q. Magly*

13. Birthplace

Dearborn Michigan

14. Maiden name

Virginia Repp Myers

15. Birthplace

Oregon Bluff

16. Informant

Mrs. Virginia Repp Myers Magly
 Address *Union Bridge Rd.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Mar 7 - 45*
 (month) (day) (year)

Cemetery or crmry

Beaver Dam Cem.

Location

Union Bridge Md

18. Funeral director

Raymond T. Wright

Address

Union Bridge Md

19. Date rec'd by registrar

7 March 1845

(Date rec'd by registrar)

Elizabeth G. Hecker
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Md Carroll

City or town

No location

Street No.

Union Bridge

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 7 1945 at 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Mar 6 1945 to Mar 7 1945*and that I last saw her alive on *Mar 6 1945*

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Hagg M. D. or other

Address

Union Bridge Date signed *3-7-45*

ITEMS TO THE VARIOUS STATE CHAIRMAN

THROUGH THE SECRETARIES

